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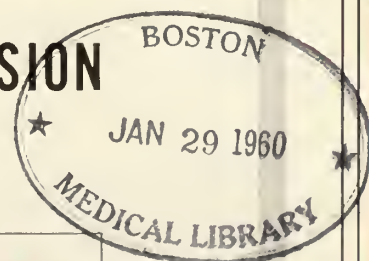
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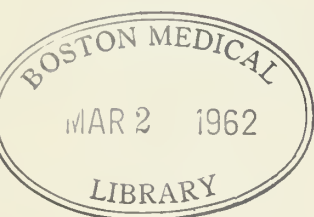
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The Journal

of the

South Carolina Medical Association

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REPORT ON FIVE THOUSAND CONSECUTIVE ELECTRO-SHOCK TREATMENTS WITHOUT COMPLICATIONS

J. J. CLECKLEY, M. D., G. H. ORVIN, M. D. AND W. C. MILLER, M. D.*
CHARLESTON, S. C.

When electric shock treatment is modified through the use of Sodium Pentothal, (thiopental sodium) and succinylcholine chloride, complications for practical purposes can be practically eliminated. The method also reduces the number of contraindications to treatment to a minimum. The following is a report of our experience with the administration of 5,000 consecutive electro-shock treatments to 612 patients over a four year period. Actually close to 10,000 consecutive treatments have been given, but only the first 5,000 are being reported upon at this time. In the reported series, there were no complications related to the treatment itself.

Electric shock as a method of treatment of certain emotional and mental disorders has gained widespread acceptance following the method of Cerletti and Bini. Its most effective application is in the affective disorders where there is a consistent and pathological variation of mood whether it be in the area of mania, depression, or excitement. It is also effective, as a rule, in early acute schizophrenic disease as well as obsessive compulsive reactions when the patient has decompensated with the development of severe depression and agitation. A recovery rate varying from 95 to 98% has been consistently reported in involutional depressive reactions. The original treatment technique consisted in the administration, through electrodes placed on each temporal region, of a measured amount of current for a measured period of time. The voltage and

amperage usually used averaged around 120 volts at 300 milliamperes. The time factor is usually three-tenths of a second. When the treatment was given successfully it always resulted in a rather severe generalized convulsion of the grand mal type. The treatment is still an empirical one as no satisfactory explanation has been given as to its mode of action. It is known that in order to be therapeutically effective a grand mal convulsion must ensue. Unmodified electric treatment is just as therapeutically effective as modified treatment; however, there were certain disadvantages associated with unmodified treatment which are not present in electro-shock modified by pentothal and succinylcholine. In the unmodified type the electrode and the mouth gag are applied with the patient in a conscious state and also there was some form of physical restraint in anticipation of the severe seizure. These factors contributed to apprehension on the part of the patient and acute dislike of the procedure. Complications of the treatment were unfortunately relatively common, in particular, fractures, due to the severity of the muscular contractions. In a given series of patients it could be roughly anticipated that three to four per cent of the patients receiving treatments would sustain fractures at some time during the course of treatment. The most common site of fracture was the dorsal spine with compression fracture of the body of the vertebra. Also, there have been reported fractures of the cervical and lumbar vertebrae, the humerus, femur, scapula, and penetration of the acetabulum by

*From the Department of Psychiatry, Medical College of South Carolina.

the head of the femur. Dislocations particularly of the shoulder and jaw were also fairly common complications. Death from unmodified electro-shock treatment is fortunately rare, only 254 deaths having been reported since the advent of this type of treatment. Most of these deaths have been attributed to cardiovascular complications such as cardiac arrest, cardiac rupture, coronary thrombosis and cardiorespiratory failure. Because of the severity of the muscle contractions and the strain on the cardiovascular system, treatment was contraindicated in a number of patients who otherwise might have benefitted from its use. The contraindications included serious cardiovascular disease, especially myocardial disease, aneurysms, coronary insufficiency, recent and old coronary occlusions, unhealed fractures, osteoporosis, severe arthritis and acute infections.

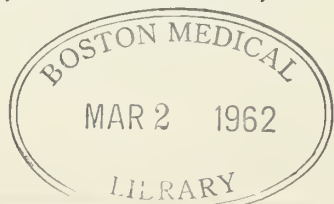
Various efforts have been made to modify treatment so that complications could be avoided at the same time maintaining therapeutic effectiveness. A slow current rise up to the maximum peak, the so-called Glissando technique, which eliminated the severe initial jolt, helped to a limited extent but was not successful in avoiding most of the complications. Modification of the current itself, the so-called unidirectional or brief stimulus treatment avoided complications but proved to be not as effective therapeutically. Drugs of the curare family were generally unsatisfactory because of their prolonged actions, also some of the deaths reported, attributed to electric shock therapy, were probably caused by curare. Finally, approximately five years ago succinylcholine chloride was developed which seemed to fill the need for a short-acting safe muscle paralyzing agent. This drug acts by first overstimulating and then paralyzing the motor end plate, producing either complete or partial muscular paralysis, depending upon the dosage used. In younger and middle age persons maximum paralysis is usually induced in one minute or less, and return of muscle tone, adequate for voluntary respiration, usually occurs in three minutes or less. In older persons with slower circulation times, a somewhat longer period of time is required for complete paralysis and for recovery, but rarely does

this exceed five minutes. Since becoming paralyzed in a conscious state would be a horrifying experience for the patient, it is necessary to use a short duration anesthetic prior to the administration of the succinylcholine.

For the past four and one-half years all electric shock treatments given on the Psychiatric Services of the Medical College and Roper Hospitals have been modified with Pentothal Sodium and succinylcholine. The technique is described as follows:

Technique

After the patient has been evaluated and the desirability of electric shock treatment established, a treatment program is set up usually consisting of three treatments per week, this appearing to be the optimum frequency in the majority of cases. On the evening before treatment, Sodium Amytal (isoamylmethyl barbituric acid) is given by mouth and nothing is allowed by mouth after midnight. The next morning atropine sulfate, 1/75 grain, is given hypodermically about one hour before treatment. At the time of the treatment the equipment is placed in the patient's room, the patient being treated in his or her own bed. Personnel required are the physician, who administers the shock treatment; the anesthesiologist, who administers the anesthetic, maintains a free airway, and administers oxygen under positive pressure during the period of apnea; and a nurse who places the electrodes and inserts the mouthpiece just prior to the administration of treatment. The patient lies in supine position with the head supported by a pillow and no restraints used. A 2½ percent solution of Pentothal Sodium is administered rapidly intravenously to the point of unconsciousness. The dosage required averages between 150 and 250 milligrams. This is immediately followed by the rapid injection, through the same needle, of 40 to 60 milligrams of succinylcholine, the dosage varying somewhat with the size and muscular volume of the patient. Almost immediately fine muscular fasciculations begin in the face, the arms, and are then followed by fasciculations of the lower extremities. This is due to initial overstimulation of the motor end plate. When these cease paralysis is usually complete and the muscles are toneless. Oxygen is ad-



ministered under positive pressure during the stage of paralysis. When paralysis is complete, a soft rubber mouth gag is introduced and the electrical stimulus, 120 volts at 300 milliamps for 3/10 of a second is administered. Concomitantly with the administration of the stimulus, there is a slight contraction of the jaw muscles and plantar flexion of the toes, this representing the tonic phase of the seizure; this is followed by a fine rhythmic twitching of the eyebrows and the toes. This generally ceases in approximately 35 seconds, marking the termination of the grand mal seizure. After the patient resumes normal respiration, he is left in the care of an attendant until consciousness is regained. This, usually requires ten to fifteen minutes and then the patient is given breakfast. About half of the patients complain of headache following recovery, which is usually relieved by aspirin. There is also mental confusion for about one hour.

This method of treatment has obvious advantages. Among them are:

1. The patient knows nothing of the procedure except being given Sodium Pentothal and therefore is spared considerable apprehension.

2. He remains well oxygenated throughout, thus avoiding hypoxia.

3. Blood pressure levels remain relatively stable throughout the treatment and there is practically no strain thrown upon the cardiovascular system.

4. Muscle contractions are held to an absolute minimum. There is virtually no possibility of muscle-skeletal injury.

5. Lastly, the patients awaken quietly and do not exhibit the troublesome post-shock excitement frequently seen in the unmodified type.

The safety and therapeutic effectiveness of this method has been well borne out in our experience. In the past four and one-half years in a series of over 5,000 consecutive treatments there has not been a single medical complication. Because of the safety factor a number of patients were treated who probably could not have withstood unmodified treatment without serious complications. The ages of the patients

varied between 15 and 83, with 25% of the patients being above 60 years of age and 45% between the ages of 40 and 59. A number of cases of hypertensive and arteriosclerotic vascular disease with electrocardiographic evidence of myocardial damage were treated without incident. We did not, however, attempt treatment in any case with a coronary occlusion under two months of age or patients in congestive failure. Among some of the medical and surgical complications encountered and treated successfully were recent fractures, severe pulmonary emphysema, glaucoma, and detached retina. One case in particular, worthy of mention, is that of a 65 year old female in a severe retarded depression. Examination revealed that she had hypertensive cardiovascular disease, diabetes mellitus, anterior and posterior myocardial infarctions, one occurring six months and the other five months prior to her admission and an abdominal aortic aneurysm approximately the size of a grapefruit. The surgical consultant refused to consider repair of the aneurysm because of the severity of the depression. A course of 12 treatments were given without incident and with complete recovery from the depression. This patient died at home some two years later presumably of another coronary occlusion or rupture of the abdominal aneurysm.

Summary

Report is made of over 5,000 consecutive treatments given to 612 patients over 4½ years utilizing the Pentothal-succinylcholine technique. There were no complications in this series of treatments. A variety of psychiatric conditions were treated and the cases were largely unselected so far as medical status was concerned. A number of cases presented medical diseases which would ordinarily have contraindicated treatment with the older techniques. All of these cases were treated without incident. The only contraindications which were observed were coronary occlusion within the two months preceding treatment and congestive heart failure. Treatments with this technique were more acceptable to the patient and were given with a minimum of discomfort and apprehension.

KIDNEY BIOPSY^{1,2}

SUMMARY OF EXPERIENCE AT THE MEDICAL COLLEGE HOSPITAL

CHEVES McC. SMYTHE³ AND FORDE A. McIVER⁴

CHARLESTON, S. C.

Since its introduction twenty years ago, thousands of aspiration biopsies of the liver have been done, and the place of this procedure in the diagnosis, treatment, and study of hepatic disease is widely understood. In 1951 Iverson and Brun described a technique for percutaneous needle (aspiration) biopsy of the kidney and the results of six such biopsies.¹ Only seven years later in another paper reviewing 500 kidney biopsies done at the Commune Hospital, Copenhagen,² Brun mentions the results of at least 1800 renal biopsies which had already been published. Another review of 500 biopsies by Kark³ and his group has subsequently been published. In another paper considering the applications of renal biopsy, Brun⁴ mentions over 100 papers in his bibliography. This procedure has evoked such widespread interest that probably at least as many biopsies have been unreported as reported.

The first percutaneous aspiration biopsy of the kidney done at the Medical College Hospital was in early 1957. This procedure has been carried out with increasing frequency since then, and this paper is a review of the first 51 such biopsies. Many of these patients were studied and biopsies were performed either by Dr. Arthur V. Williams or Dr. Kenneth M. Lynch, Jr. Without their kindness, much of this data would never have been collected.

Biopsy Technique: This procedure is explained in detail to the patient who must give his consent. Bleeding, clotting, and prothrombin times are obtained to rule out a bleeding dyscrasia. Intravenous or retrograde pyelograms or a plain film of the abdomen with which to localize the kidney accurately are a necessary predicate to biopsy. One wishes to obtain a specimen from the cortex of the lateral portion of the lower pole of the kidney. The distance to

this point is measured on the radiographs from the lower edge of the 12th rib in the posterior mid-clavicular line and from the spinous process of the second lumbar vertebra. The patient is prepared by withholding food for at least 6 hours, by giving small doses of meperidine and a barbiturate, and by being placed in the prone position on a hard surfaced examining table. A sand bag is placed under the mid-epigastrium to force the kidney against the posterior renal fascia and to hold it in position. After the spinous processes and the 12th rib are located by palpation, a spot on the skin coinciding with the measurements taken from the radiograph is selected. After suitable surgical preparation, the skin, subcutaneous tissue, and back muscles are infiltrated with a local anesthetic. A lumbar puncture needle is used as an "exploring needle" with which to find the kidney. This organ can be readily identified by the very characteristic rocking motion imparted to the hub of the needle by the movement of the kidney induced by respiration. Also, the kidney has a firm surface and is somewhat more sensitive than other structures. The exploring needle is then withdrawn and the biopsy needle (Franklin modification of the Vim-Silverman needle) is inserted to the surface of the kidney. The patient is asked to hold his breath in mid-inspiration, and the biopsy, in which tissue is taken from the cortex, is completed in a few seconds. The right kidney is usually selected for biopsy, but the left is approached with almost equal ease.

It is explained to the patient that some blood in the urine and flank discomfort may be expected after the procedure. Less than 30% of our patients have reported any pain or bleeding. In only one instance has there been gross hematuria. In no instance has the flank pain been severe enough to require more than one dose of additional analgesic. After completion of the procedure, all patients are asked if they would be willing to undergo it a second time if indicated, and the answer has been universally affirmative. Most report that the biopsy is much less uncomfortable than tooth extraction. Although more difficult, technically, patients seem to mind kidney biopsy less than liver biopsy and certainly have much less post-biopsy pain. After the biopsy, the patients are asked to remain at bed rest for 24 hours. Blood pressure and pulse are regularly checked for the first 4 hours after biopsy.

Pathologic Technique: The biopsy specimen, which is ideally about 15 mm. in length, is placed on a small piece of absorbent paper to hold it flat and dropped immediately into the fixative of choice. In this laboratory sections were originally cut at 6 micra, but more recently at 3 micra. For the study

1. From the Departments of Medicine and Pathology, Medical College of South Carolina.
2. Supported in part by grants from the Saul Alexander Foundation and Hoffman LaRoche.
3. Assistant Professor of and Markle Scholar in Medicine.
4. Assistant Professor of Pathology.

of basement membranes with the periodic acid-Schiff (PAS) stain, thinner uniform sections are essential, and 3 to 4 micra is probably a reasonable thickness for all of the usual stains, including PAS. Special stains for amyloid and connective tissue occasionally offer some refinement of interpretation. Fat stains would be desirable, but cannot be done on paraffin embedded material. A second biopsy for fat stains is probably seldom justified.

RESULTS: Biopsies have been attempted in 72 patients. In 51 cases enough tissue has been obtained to make a diagnosis, and in 7 others recognizable renal tissue insufficient for diagnosis has been obtained. There have been 13 failures to obtain any tissue. Four of these can be attributed to lack of experience, six to contracted kidney or obesity, one to an unexpected burst of bleeding from the needle, and two failures are unexplained. The first 10 adequate biopsies required 16 attempts (62% successful) and the last 41 biopsies, 56 attempts (73% successful). No major complications have ensued.

Table I lists the findings in 51 successful biopsies. A few comments will be made about each group of cases, which are listed according to pre-biopsy diagnosis. Figure 1 is an illustration of a normal glomerulus.

Pyelonephritis: These 20 biopsies were done as part of a long term study on the effects of long continued chemotherapy on the course of pyelonephritis. Patients with all degrees of severity of renal diseases are included in this group. Since pyelonephritis is a focal lesion, it is not surprising that 6 of 20 were found to have histologically normal kidneys. Four others had varying degrees of nephrosclerosis without evidence of pyelonephritis. Seven had pyelonephritis present in varying degrees of severity and two of these had nephrosclerosis in addition. Perhaps most interesting were the three patients with clinical diagnosis of pyelonephritis in whom evidence of glomerulonephritis was found. One of these patients has flagrant active, chronic genitourinary infection and has responded well to active anti-bacterial treatment. The other two patients had the diagnosis of glomerulonephritis made by biopsy. Since renal diseases can exist in combination and pyelonephritis may be present histologically in the absence of a positive urine culture (three patients in

the total group) biopsy has real diagnostic merit even in this most focal of renal diseases. Figures 2 and 3 are examples of pyelonephritis in the absence of a positive urinary culture, and figure 4 is typical of combined pyelonephritis and nephrosclerosis.

Nephrosis: The clinical diagnosis of nephrosis may be the expression of a wide variety of renal lesions. Of the seven patients clinically nephrotic, two had proliferative glomerulonephritis (Figs. 6 and 7), one had membranous glomerulonephritis (Fig. 5), and three had a mixed lesion, and one had glomerulosclerosis. Biopsy is most useful in this group of cases, not only for a more exact diagnosis but also as a prognostic aid.

F. M. a 47 year old Negro farm worker was admitted to the Medical College Hospital with anasarca. He had previously been treated with steroids at McLeod Infirmary by Dr. N. B. Baroddy for the same condition. Besides anasarca, physical examination was essentially negative. Blood pressure was 140/100 mm Hg. The urinary specific gravity was 1.015, blood urea nitrogen 34 mg. per 100 ml. and endogenous creatinine and urea clearances were 30% of normal. Biopsy (18 glomeruli) revealed a kidney with proliferative glomerulonephritis in which the changes were relatively minor (Figure 6). The glomeruli were hypercellular, the basement membranes thickened, but none was hyalinized and only one crescent was found. Even though this man was azotemic at the time of biopsy, this biopsy suggests a better prognosis than one might expect from his clinical picture. It gives the physician a better indication for steroid therapy and suggests better chances for success.

Glomerulonephritis: Under the diagnosis of glomerulonephritis are included many entities—e.g. clinically are listed acute, subacute, chronic, and healed glomerulonephritis as well as nephrotic nephritis. Pathological diagnoses include membranous, proliferative, and exudative glomerulonephritis of varying degrees of chronicity. Certainly there are many etiologies for the changes in glomeruli called glomerulonephritis.

Of the 10 patients diagnosed as having glomerulonephritis (Table 1), 2 were classified as having normal kidneys histologically, 7 as having some form of glomerulonephritis, and 1 as having myoglobinuric nephrosis, a new entity in our experience. Some points are illustrated by the following two brief case reports.

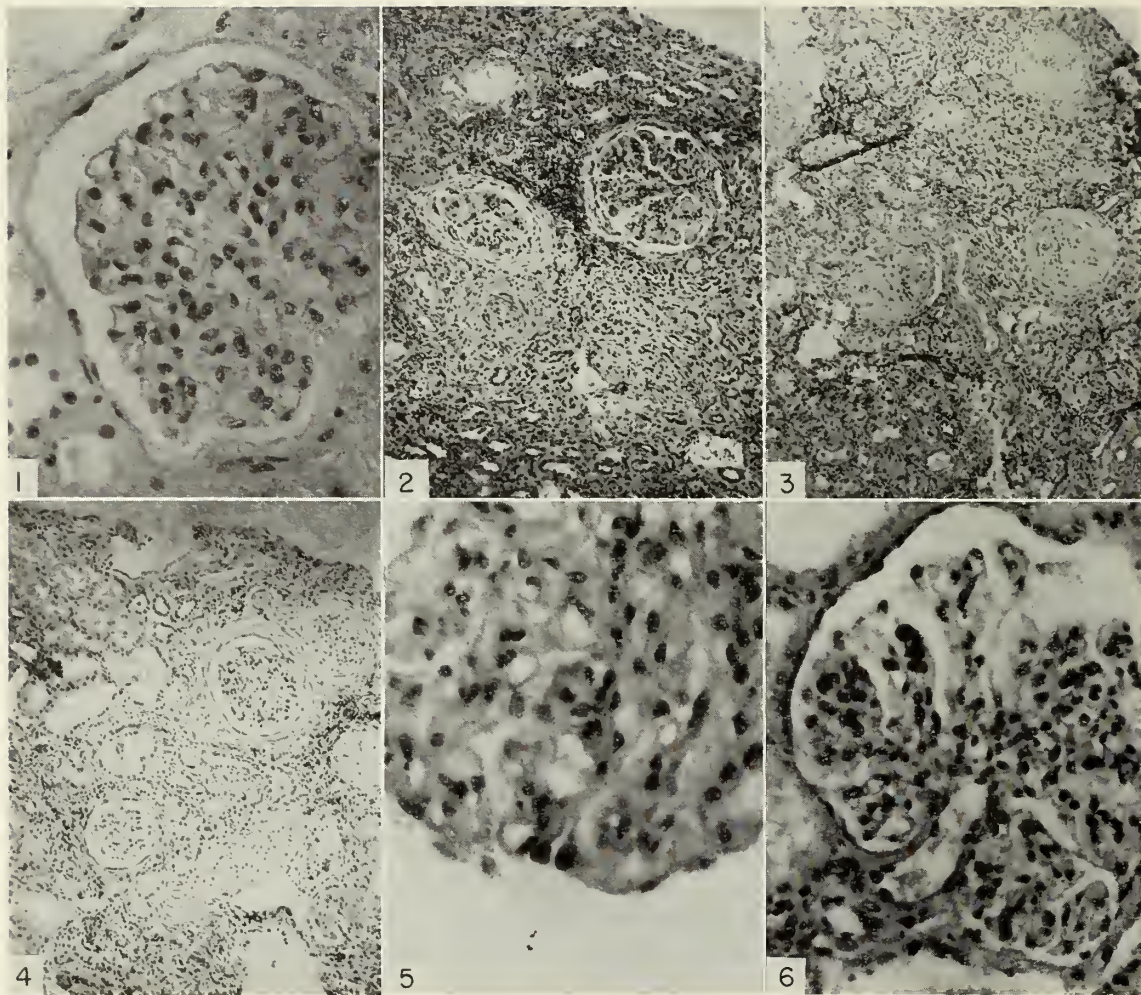


Fig. 1. X about 400. A normal glomerulus from a man with hematuria of unknown cause. Note the lacy character of the capillary walls and the presence of red cells in the capillary loops. The basement membrane of the capillaries is a fine line. The capillary tufts are separate and are relatively widely separated from the Bowman's capsule. The glomerulus is less cellular than in the cases with glomerulonephritis.

Fig. 2. X 100. Chronic pyelonephritis: This woman has had long standing disease and is hypertensive with limited renal function. Note the periglomerular fibrosis, the inflammatory response in the interstitial tissues and the thickened arteriole. An unusual feature is the appearance of the amyloid-like material infiltrating the glomeruli. This woman is not diabetic. Urine cultures are sterile.

Fig. 3. X 100. This 17 year old boy is a known diabetic with azotemia. Glomerulosclerosis was the pre-biopsy diagnosis, but this far advanced pyelonephritis

was found. Note the hyalinized glomeruli, inflammatory cells, and fibrosis. Urine cultures were sterile. This and Fig. 2. are possible examples of bacterial interstitial nephritis.

Fig. 4. X 100. Classic chronic pyelonephritis with superimposed nephrosclerosis. This woman also has severe hypertension and limitation of renal function. Note the thickened arterioles and hyalinized glomerul in addition to the interstitial fibrosis.

Fig. 5. X about 400. Membranous glomerulonephritis. Note the thickened basement membranes, the absence of red cells, the coalescence of the glomerular tufts and the cellular appearance of the glomerulus.

Fig. 6. X about 400. Early proliferative glomerulonephritis. Note the increased cellularity of the glomerulus and how swollen it is. There is no fibrosis and nothing to suggest that this is an irreversible lesion, yet this man was azotemic at the time of this biopsy.

G.H. a 30 year old white male was admitted with mild hypertension (blood pressure 160/110 mm. Hg. and persistent proteinuria. His history was of recurrent febrile attacks suggestive of pyelonephritis. Renal function was good. There were no red cell casts in the urine. On biopsy (8 glomeruli) changes

of active proliferative glomerulonephritis were found.

This diagnosis allows one to advise this man about weight control, rest, blood pressure, control, and management of his illness with considerably more security than if this information were not available.

B.F. a 21 year old Marine recruit, arrived at the

Marine training depot at Parris Island four days before the onset of his acute renal disease. His previous sedentary existence as a university student had left him ill prepared for the rigors of recruit physical training. He developed acutely malaise, fever, hematuria, and finally oliguria, because of which he was referred to the Medical College Hospital for dialysis. Urinary output rose, and dialysis was not necessary. On biopsy only a fair sample of tissue was obtained. However, the glomeruli were normal, but the tubules were filled with pigment and casts.

In this man, unaccustomed to exercise, strenuous physical exertion presumably led to breakdown of large amounts of muscle with release of its pigment. This resulted in disruption of the renal tubules and oliguria. Since this case was discovered, other less severe instances of this entity have been noticed at Parris Island and are being reported by Howenstein.⁶ This patient is apparently completely well at present.

P.T., an 18 year old white female, had had intermittent episodes of flank pain with chronic proteinuria of fluctuating severity. Physical examination was negative save for scoliosis. Renal function was excellent and urological investigation negative. On renal biopsy only healed glomerulonephritis was found. This diagnosis allows one to attribute her pain to the scoliosis and to advise her with more confidence on the significance of her proteinuria.

Essential Hematuria: Not infrequently one discovers individuals with persistent hematuria for which no cause can be found using standard urological investigative techniques. Five such patients have been examined by biopsy, and three were found to have normal kidneys microscopically (Fig. 1). In two, however, an acute glomerulonephritis was present (Fig. 9).

M.K., a 36 year old white female had had repeated episodes of hematuria for which no explanation could be found. On biopsy her glomeruli were swollen and hypercellular. Some were bloodless and two of the 38 in the specimen were hyalinized. There was mild periglomerular fibrosis. The picture was consistent with an acute glomerulonephritis.

Collagen Diseases: Four patients (2 with lupus erythematosus, one with suspected lupus, and one with suspected polyarteritis) have had biopsies in this group. Two had normal kidneys, one minimal glomerular changes, and one acute glomerular changes (Fig. 10). The last has since died of progressive renal disease. Muhreke⁷ and his group have described in detail the various changes in lupus seen on renal biopsy.

Miscellany: One man with a suspected diagnosis of carcinoma of the kidney had this

diagnosis substantiated on aspiration biopsy of his flank. One young woman with healed subacute bacterial endocarditis and marked decrease of renal reserve, in whom the pre-biopsy diagnosis was focal embolic nephritis, was found to have a modest degree of pyelonephritis on biopsy. A young man with diabetes and azotemia did not have diabetic glomerulosclerosis on biopsy but rather severe pyelonephritis (Fig. 3). This is probably an example of the bacterial interstitial nephritis described by Kark.⁸ A woman with surgical hypoparathyroidism and myxedema was found to have chronic pyelonephritis histologically. The last case is described in more detail.

J.M.S., a 35 year old farm laborer had had known hypertension for 15 years when he suddenly developed left sided weakness after working in the sun for a number of hours. He was hospitalized and treated with various antihypertensive medications including chlorthalidate. His course was downhill with progressively severe drowsiness, hiccups, anorexia, oliguria and azotemia. He was transferred to the Medical College Hospital with the diagnosis of possible acute renal failure but the probability of sodium depletion was noted. After 1500 ml. 0.9% Na Cl., his blood urea nitrogen was 28 mg. per 100 ml., serum sodium 130.5, and chloride 94.6 m. Eq./l. Biopsy revealed only arteriolar thickening without evidence of glomerular damage or of malignant nephrosclerosis.

These findings dictated correcting his sodium depletion and will condition subsequent therapy by his referring physician.

Discussion

Contraindications: No biopsies have been done in patients with bleeding tendencies. None has been done on an individual with a single kidney. No one with recognized accelerated hypertension or with profound uremia has had biopsy. Azotemia has not been considered a contraindication nor has oliguria, although we have done biopsy on no one with anuria. Others have performed biopsy on kidneys in some of the above situations, but bleeding tendency and single kidney are widely recognized as strong contraindications. Severe arteriosclerosis should also be considered a relative contraindication. Also, only some compelling reason should lead one to do a biopsy on a so-called "surgical kidney" (hydronephrosis or pyonephrosis, etc.). Operable malignant renal neoplasms should not be subjected to needle biopsy, but, if this

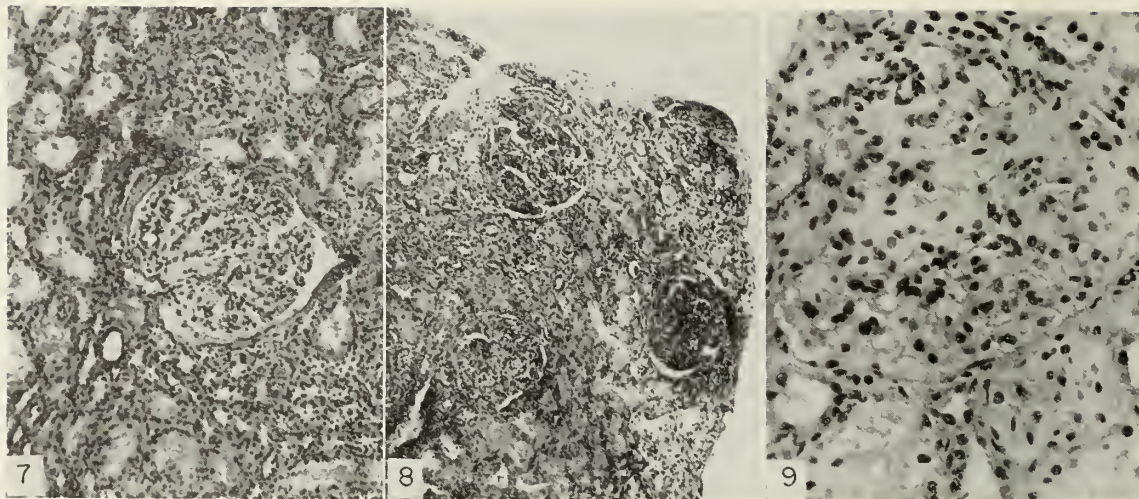


Fig. 7. X 150. Proliferative glomerulonephritis. This young epileptic woman has the classic nephrotic syndrome. Note the hypercellular swollen glomerulus, partially attached to Bowman's capsule with beginning crescent formation.

Fig. 8. X 100. Acute exudative glomerulonephritis. Note the swollen glomeruli infiltrated by inflammatory cells. Crescent formation is already beginning.

This man had only severe hematuria as symptomatic evidence of his disease. Renal function was reduced.

Fig. 9. X about 400. Lupus nephritis. An abnormal glomerulus from a young woman who subsequently died of inexorably advancing lupus nephritis.

In this photomicrograph this lesion cannot be differentiated from other processes affecting the basement membrane.

is done, the needle tract should be excised *en bloc* with the skin and kidney.

Precautions: Although never necessary in this experience, transfusion has been indicated elsewhere because of bleeding. Therefore, typing and cross-matching blood prior to the procedure is advocated by some. Made secure by superb blood banking facilities, our group has not done this routinely. Biopsy is performed only on in-hospital patients. Failure to visualize the kidney roentgenographically so destroys the operator's confidence that this group has gone to some pains to obtain satisfactory films prior to biopsy. Since the patient must cooperate, it is wise to take time to see that he understands what is to be done before starting. This has not been a problem in either service or private patients. The youngest case in which we have done a biopsy is a 12 year old girl. Others have reported successful biopsies in non-anesthetized children younger than this. In younger children general anesthesia is advocated. With bag breathing a biopsy can easily be done in small children. It has been widely recommended that biopsies not be done casually, but only by those prepared to become expert at it. If for no other reason, the greater an

operator's experience, the greater his chance of getting a good sample of tissue. Finally, the clinician doing these biopsies must be prepared to read the results with the pathologist or provide the laboratory with clinical data in considerable detail.

Complications: No serious complications have been encountered in this group of patients to date. Some individuals have noted minor degrees of hematuria, and microscopic hematuria has been noted in those persons in whom the urine was examined. Microscopic hematuria is to be expected after biopsy and is an almost inevitable accompaniment of success. In but one individual did we have significant gross hematuria, and this subsided at the end of 12 hours. A transfusion was not necessary. In another patient a hematoma developed in the flank which was somewhat uncomfortable, but required neither transfusion nor any other treatment. One patient developed moderate ureteral type pain for about an hour after the biopsy. This was an unsuccessful attempt. There have been no long term complications. No transfusion have been required. No operative intervention has been called for.

Number	Patient	Clinical Diagnosis	Degree of Functional Impairment	Pathological Diagnosis	Degree of Histological Damage
PYELONEPHRITIS					
1	LMD	Chronie Pyelonephritis	Severe	Chronie Pyelonephritis	Severe
2	RS	Healed Acute Pyelonephritis	None	No Disease	None
3	EB	Chronie Bacteriuria	None	No Disease	None
4	EB	Chronie Pyelonephritis	Slight	Nephrosclerosis	Slight
5	LD	Chronie Pyelonephritis	Moderate	No Disease	None
6	AH	Chronie Pyelonephritis	Moderate	No Disease	None
7	EF	Chronie Pyelonephritis	Moderate	Nephrosclerosis	Slight
8	HE	Chronie Pyelonephritis	Moderate	Chronie Pyelonephritis Nephrosclerosis	Moderate
9	WP	Chronie Pyelonephritis	None	Minimal Pyelonephritis	Minimal
10	LS	Chronie Pyelonephritis	Slight	Chronic Pyelonephritis	Slight
11	DC	Baeteriuria— Glomerulonephritis	None	Proliferative Glomerulonephritis	Slight
12	SW	Chronie Pyelonephritis	None	Normal Kidney	None
13	VJ	Chronie Bacteriuria	None	Chronie Pyelonephritis	Slight
14	GD	Nephrolithiasis Possible Pyelonephritis	Slight	Aeute Glomerulonephritis	Slight
15	RS	Chronie Pyelonephritis	Moderate	Chronic Pyelonephritis	Moderate
16	AN	Chronie Pyelonephritis	Slight	Nephrosclerosis	Slight
17	JH	Chronie Pyelonephritis	Severe	Proliferative Glomerulonephritis	Moderate
18	LP	Chronic Pyelonephritis	Slight	Glomerulosclerosis	Moderate
19	VB	Chronic Pyelonephritis	Slight	Nephrosclerosis	Moderate
20	MC	Chronic Pyelonephritis	Moderate	Chronie Pyelonephritis	Moderate
NEPHROSIS					
21	FM	Toxie Nephrosis	Severe	Proliferative Glomerulonephritis	Moderate
22	JS	Nephrosis	Moderate	Proliferative Glomerulo- nephritis	Slight
23	HR	Nephrosis	None	Proliferative and Mem- branous Glomerulonephritis	Slight
24	WS	Toxie Nephrosis	Moderate	Membranous Glomerulo- nephritis	Slight
25	MP	Nephrosis	None	Membranous Glomerulo- nephritis	Slight
26	GJ	Glomerulosclerosis	Severe	Glomerulosclerosis	Severe
27	GH	Nephrotic Nephritis	Severe	Mixed Membranous and Proliferative Glomerulo- nephritis	Moderate
GLOMERULONEPHRITIS					
28	RP	Aeute Glomerulonephritis	Very Severe	Acute Glomerulonephritis	Very Severe
29	BF	Acute Glomerulonephritis	Severe	Myoglobinurie Nephrosis	Slight
30	GH	Chronie Glomerulonephritis	Slight	Proliferative Glomerulonephritis	Slight
31	AB	Chronie Glomerulonephritis	None	Normal Kidney	None
32	EB	Chronie Glomerulonephritis	Slight	Proliferative Glomerulonephritis	Slight
33	CR	Chronic Glomerulonephritis	None	Membranous Glomerulo- nephritis	Slight
34	AW	Chronie Glomerulonephritis	Moderate	Proliferative Glomerulonephritis	Moderate
35	WB	Membranous Glomerulonephritis	Slight	Normal Kidney	None
36	NL	Membranous Glomerulonephritis	Slight	Membranous Glomerulo- nephritis	Slight
37	PT	Membranous Glomerulonephritis	Slight	Healed Glomerulo- nephritis	Slight
ESSENTIAL HEMATURIA					
38	RJ	Renal Hematuria	Severe	Acute Glomerulonephritis	Severe
39	BJ	Renal Hematuria	None	Normal	None
40	JH	Renal Hematuria	None	Normal	None
41	LG	Renal Hematuria	None	Normal	None
42	MK	Renal Hematuria	None	Acute Glomerulonephritis	Moderate
COLLAGEN DISEASE					
43	CT	Lupus Erythematosus	None	Normal	None
44	BW	Lupus Erythematosus	Slight	Glomerulitis	Slight
45	MA	Polvarteritis Nodosa	None	Normal	None
46	AB	Possible Lupus	Slight	Minimal Glomerulitis	Slight
MISCELLANY					
47	MM	Hypoparathyroidism	Moderate	Chronic Pyelonephritis	Moderate
48	IV	Focal Embolic Nephritis	Moderate	Chronic Pyelonephritis	Slight
49	JC	Glomerulosclerosis	Severe	Chronic Pyelonephritis	Severe
50	IY	Carcinoma of Kidney	—	Carcinoma of Kidney	—
51	JS	Nephrosclerosis Hyponatremia	Severe	Nephrosclerosis	Slight

Indications

Within the limitations discussed above, any one with diffuse renal disease has an indication for biopsy. However, the huge experience with surgical biopsy in hypertensive disease⁹ has demonstrated that biopsy does not very often give much additional information on these patients. In selected cases, for instance to prove or disprove a suspected diagnosis of glomerulonephritis or pyelonephritis, biopsy may be of value. The focal nature of pyelonephritis does not lend itself too well to study by aspiration biopsy. Even so, this disease was discovered by biopsy in three of our cases (Fig. 3). However, in the study of the nephroses, many chronic proteinurias, lupus erythematosus, the glomerulonephritides, unexplained hematurias, vascular and inflammatory diseases, and diabetic renal disease, biopsy has been of greatest value. In addition to its application as an extension of diagnostic techniques, biopsy is of value in prognosis. It has been demonstrated repeatedly that information gained from the study of six or more glomeruli can be interpolated to all of both kidneys. It is fair to conclude that the degree of glomerular damage found in one biopsy specimen gives an idea of what might be expected elsewhere in the kidney. This is of especial value in patients with otherwise unexplained albuminuria.

The third major application of biopsy is in clinical investigation. The studies of Kark et. al.⁷ of lupus nephritis and of Berman and Schreiner¹⁰ of the nephroses are examples of intensive application of this technique to the study of single entities. Perhaps the most significant advances to be made with the aid of this technique lie in basic renal research. Already electronmicroscopic studies of biopsy

specimens from individuals with a variety of glomerular disease have proved that the changes in the microstructure of the glomeruli in acute glomerulonephritis are different from those in nephrosis. Farquhar, Verneir and Good¹¹ have described distortion of the epithelial foot processes as the early consistent change in nephrosis. In glomerulonephritis there are pronounced proliferative lesions involving the endothelium of the glomerular capillary with thickening of the basement membrane and normal epithelial foot processes. In mixed nephrosis-nephritis, a mixed lesion is seen. In disseminated lupus there is marked thickening of the basement membrane and a variable degree of endothelial proliferation. These changes are seen most distinctly early in the disease process and as the disease progresses to scarring, the increasingly hyalinized glomeruli appear quite similar in all three conditions. The ultramicroscopic structure of the tubules is also being extensively explored at present. Fluorescence studies of allergic phenomena in renal disease are now in progress by Pratt-Thomas¹² at the Medical College of South Carolina. This technique is ideally suited to the use of biopsy material.

Summary and Conclusions

(1) Successful percutaneous aspiration biopsies of the kidney have been done in 51 individuals at the Medical College Hospital. There has been no significant morbidity and no mortality.

(2) The technique of biopsy is described and the indications and contraindications for biopsy are discussed.

(3) Renal biopsy is a useful tool in the diagnosis, management, and study of a great variety of renal diseases.

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TRIAMCINOLONE ACETONIDE (KENALOG) INJECTED INTO JOINT AND MUSCLE

A CLINICAL STUDY

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SPARTANBURG, SOUTH CAROLINA

Direct instillation of locally-active corticosteroids into articular spaces has proved a useful means of selectively and individually treating one or several joints affected with an acute and painful inflammation.¹⁻⁶ Where systemic therapy is contra-indicated or fails to control peripheral joint involvement adequately, or cannot do so without use of higher and perhaps poorly tolerated dosage, intra-articular injection is a practical palliative measure. While benefits may be temporary, they are repeatable and can be sustained or re-induced by subsequent injections.³ Amelioration of pain and stiffness is prompt and generally followed by a lessening of joint swelling and greater freedom of motion. The response is often rewarding even when pain and disability are pronounced.

Potency in terms of weight units of the corticosteroid instilled is an important influence on degree of improvement and duration of effect. Strict limitations on the volume of material injected and, consequently, on therapeutic activity are imposed by joint capacity and by the availability of a sufficient area of synovial tissue to permit efficient absorption of therapeutic quantities of the corticosteroid.⁴ Many accessible joints which frequently require local treatment are small in size. Although, in larger joints, quantitative and qualitative enhancement of benefits may be achieved through instillation of larger doses there is some question of an "overflow effect" leading to systemic manifestations which suggests maximum dosage restrictions, at least for hydrocortisone.⁴ Whether or not systemic effects can be completely avoided, local considerations require the skillful introduction into joint space or bursa or muscle tissue of a high level of anti-inflammatory activity in relatively small volume and in low dosage.

Triamcinolone acetonide was supplied as Kenalog through the courtesy of Dr. R. C. Merrill, E. R. Squibb & Sons, New York.

For injection into joint and muscle, hydrocortisone acetate and its free alcohol are effective and widely-used corticosteroids. There is some evidence that hydrocortisone tertiary-butyl-acetate is somewhat longer acting but prednisone and prednisolone are not conspicuously more effective.² In the study presented here, the potent locally-active triamcinolone derivative, triamcinolone acetonide (Kenalog) was employed for intra-articular and intra-muscular injection. A suspension containing 10 mg. of corticosteroid in each ml. was available for this purpose. The results of an earlier experience were encouraging. Triamcinolone acetonide in doses of 4 to 20 mg. induced good to excellent remission of joint inflammation, pain and stiffness in 136 of 157 patients with rheumatoid disorders.⁷ In many cases, improvement in symptomatology was greater with triamcinolone acetonide than with corticosteroids previously administered and, in all cases, an equivalent or better response was achieved with appreciably lower dosage. Since March of 1959, triamcinolone acetonide has been substituted consistently for hydrocortisone in the treatment of joint and muscle disorders encountered in our private practice. Worthwhile benefits have been achieved in a high percentage of cases.

Procedure

A group of 101 patients with pain and inflammatory involvement of joint and muscle are considered in this report. Volumes of 0.5 to 5 ml. of triamcinolone acetonide suspension were instilled directly into joint spaces. Occasionally, severely affected knees received as much as 6 ml. in a single injection. During this study, 66 joints were treated, with knee and shoulder joints comprising by far the greater number (Table I). Direct injection of the corticosteroid into muscle tissue was also carried out and while this is not a general practice at present, it has been our experience

Table I.
DISTRIBUTION OF 66 JOINTS TREATED
WITH TRIAMCINOLONE ACETONIDE AND
AMOUNT OF SUSPENSION INSTILLED

Joint Injected	Number Treated	Volume of Injection*
Ankle	2	1.5 - 2 ml.
Coccyx	1	2 ml.
Elbow	3	0.5 - 5 ml.
Hip	3	2 - 5 ml.
Knee	31	1 - 6 ml.
Sacroiliac	2	2 - 5 ml.
Shoulder	19	0.5 - 5 ml.
Temporo-mandibular	2	1 - 2 ml.
Trochanter	1	2 - 5 ml.
Wrist	2	0.5 - 1 ml.

*Each ml. contains 10 mg. triamcinolone acetonide

that relief of pain and inflammation is possible with infrequent injections. In all cases, procaine was administered in conjunction with triamcinolone acetonide in the ratio of 2 ml. to 1 ml. of corticosteroid.

In general, patients received series of 1 to 4 injections involving 5 to 50 mg. of active material. Occasionally, arthritic knees were treated with as many as 6 injections and with as much as 60 mg. of triamcinolone acetonide but these cases are considered unusual rather than typical of the treatment schedule. The technic of intra-articular or intra-bursal injection is not difficult but assumes a knowledge of joint structure and a diagram or x-ray may be employed as a guide to proper placing of the needle. While strict observation of aseptic procedure is mandatory, office or out-patient facilities are satisfactory. Excess synovial fluid should be aspirated prior to administration of the corticosteroid. The only contra-indications to intra-articular use of corticosteroids is the presence of infection in or near the joint or so extensive an inflammatory disease process that local therapy becomes impractical. Diathermy and anodynes were employed adjunctively as indicated during this investigation.

Results of Treatment

On the basis of reduction in swelling and pain and increase in mobility, results were judged good to excellent in 75 (74.3%) of the cases treated with the triamcinolone acetonide suspension. Many patients experienced complete relief of pain and restoration of function to normal capacity. The degree of improvement in 15 (14.8%) cases was considered only fair because residual joint and muscle

symptoms continued to be present at the last observation prior to the writing of this report. Eleven (10.9%) patients showed a poor response with benefits inconsistent or insufficient in degree or duration to be of practical value. As may be seen from Table II, joint and muscle disorders of diverse etiology were included in this study and local therapy induced highly satisfactory palliative effects. Improvement persisted for at least three days to be considered of practical value and generally was of several months duration. Where successive injections were required, these were administered at intervals of 1 week to 2 months. In self-limited disorders, initial benefits were maintained without repeated treatment, and a single injection frequently helped to promote a more rapid return to normal activity.

No complications and no occurrences of joint infection were encountered. There were no untoward reactions due to sensitivity or to toxic effects. In one or two cases, there was a complaint of a mild burning sensation at the site of injection but this also held true for hydrocortisone and no real importance was ascribed to it. No systemic corticosteroid effects, such as improvement of uninjected joints, were observed in this series with the dosage and treatment schedule employed.

Comment

Selective and individual treatment of pain and disability by intra-articular instillation of a potent corticosteroid into a joint accessible for injection can be a rewarding experience. While the degree and duration of palliative effects appears related to extent of joint damage, the amount of weightbearing and over-use to which the joint is exposed and the mechanical skill of the physician in placing the active material within the joint space, the potency per milligram of the corticosteroid employed is an important influence on therapeutic outcome. In many instances, joint capacity strictly limits the anti-inflammatory activity which can be induced. With larger joints and larger doses, there is the question of adjusting the quantity of corticosteroid administered to the area of synovial tissue available for absorption. With quantities larger than the cells can hold, an "overflow effect"

Table II.
RESPONSE OF JOINT AND MUSCLE DISORDERS
TO LOCAL TREATMENT WITH TRIAMCINOLONE ACETONIDE

Diagnosis	Number of Patients	Dose Injected (mg.)	Number of Injections	Degree Of Improvement			
				Excellent	Good	Fair	Poor
Arthritis							
ankle	2	20	2	0	1	1	0
knee	18	20 - 60	1 - 6	1	14	3	0
sacroiliac	1	40 - 50	2	0	0	0	1
Bursitis							
hip	3	20 - 50	1	1	1	0	1
knee	4	20	1 - 2	2	2	0	0
shoulder	13	5 - 50	1 - 3	8	3	2	0
subscapular	2	20 - 50	2 - 3	2	0	0	0
trochanter	1	20 & 50	2	0	0	1	0
Charcot's Joint (elbow)	2	30 - 50	2 - 3	0	0	1	1
Muscle strain, spasm, myositis							
heel	1	10	1	0	0	1	0
lumbosacral	7	10 - 40	1 - 4	0	5	1	1
paralumbar	4	20 - 40	1	0	2	1	1
other back areas	7	20 - 50	1 - 3	0	5	2	0
neck	5	20	1	2	2	1	0
shoulder	2	10 - 30	1 - 2	1	1	0	0
Joint Pain							
Nonspecific							
sacroiliac	1	20	1	0	1	0	0
shoulder	4	20 - 50	1 - 3	2	2	0	0
temporo-mandibular	1	10 - 20	2	0	0	0	1
Traumatic Injury							
coccyx	1	20	1	0	0	0	1
knee	6	20 - 50	2 - 3	0	5	1	0
shoulder	1	20	1	0	1	0	0
temporo-mandibular	1	10	1	0	0	0	1
Pain at site of old fracture							
rib	3	30	1	1	2	0	0
shoulder	1	10 - 30	3	0	0	0	1
Post-laminectomy pain	1	20 - 50	3	0	0	0	1
Sciatica	1	20	3	0	0	0	1
Surgical scars, pruritic	2	5 - 10	1	1	1	0	0
Tennis elbow	1	5 & 30	2	0	1	0	0
Tearing of knee cartilage	3	20 - 30	1 - 3	0	3	0	0
Wrist ganglia	2	5 - 10	1 - 2	2	0	0	0
TOTALS	101			23 (22.8%)	52 (51.5%)	15 (14.8%)	11 (10.9%)

inducing systemic manifestations is a distinct possibility. Intra-articular therapy is ideally carried out by injection of material of anti-inflammatory activity in relatively small volume and in low dosage.

Investigation of the usefulness of triamcinolone acetonide for intra-articular, intra-bursal and intramuscular therapy disclosed a potent anti-inflammatory action in doses of 5 to 50 mg. While direct injection of corticosteroids into muscle tissue is not a widespread practice, clinical observation indicated that amelioration of pain and muscles spasm may be anticipated with infrequent treatments. Benefits observed in joint disorders included suppression

of inflammation, pain, swelling and stiffness, usually initiated within 48 hours and maintained for as long as 2 months. From the standpoints of potency and toleration, it is our impression that triamcinolone acetonide has a definite place in the local treatment of inflammatory and painful joint and muscle disorders. The compound shares with other corticosteroids the ability to curtail the inflammatory reaction but does so in impressively low dosage.

Summary

Good to excellent amelioration of inflammatory and painful joint and muscle disorders was achieved in 75 (74.3%) of 101 patients

treated by intra-articular, intra-bursal and intramuscular injection of triamcinolone acetate. A fair degree of improvement was observed in 15 (14.8%) patients and in the remainder, benefits were considered of no practical value. Volumes of 0.5 to 5 ml. of triamcinolone acetate suspension providing 5 to 50 mg. of active agent were generally employed. Rarely, a severely involved knee was treated with as much as 60 mg. In certain cases, a single injection was sufficient to suppress symptoms and to promote a more rapid

return to normal activity. Where repeated injections were necessary, these were given at intervals of 1 week to 2 months. No complications and no unwanted reactions occurred in this series. No systemic corticosteroid effects were observed. It is our impression that triamcinolone acetate provides a high level of anti-inflammatory activity in relatively low dosage and is a worthwhile agent for the treatment of disability and pain in joint and muscle.

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THE RICHLAND COUNTY VENEREAL DISEASE CLINIC

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The Richland County Venereal Disease Clinic serves as a prevention and control center in the co-ordinated setup of federal, state and local V-D prevention, investigation, control and treatment. There are only two such centers in the state, Charleston and Columbia, and elsewhere V-D problems are, on a public health basis, carried out by local health departments working with the State Health Department. For this function there is a special physician ready to travel to any area in the state for advice and special work such as carrying out darkfield studies. The key man in our whole V-D program is the V-D investigator and later on I will tell you more about him, his work, and how he can help you as he helps me daily. Without him our whole program would fail.

As an introduction I would like to summarize for you our work in 1958. In reviewing this it is evident that a tremendous part of our work is with gonorrhea, not syphilis, but remember, this keeps us in touch with the ever present "current" of the V-D population and helps in quickly catching, tracing out and stopping syphilis when it appears, and as each case of syphilis is potentially an epidemic, anything that keeps us close to its source is valuable. In a way our contacts with cases of gonorrhea serve as diplomatic listening posts or chains of radar stations which are outposts most liable to pick up earliest contact with the enemy (syphilis).

During 1958 our clinic treated 94 cases of syphilis, eighteen cases of early syphilis and 23 cases of early latent syphilis. This means that 43% of our cases were infectious. In addition there were 45 cases of late latent, 5 congenital and 3 cases of neurosyphilis.

Nine hundred and twenty-five cases of gonorrhea were treated. Of these 528 were patients who had never before been treated in

our clinic for gonorrhea. This means that nearly 57% of our gonorrhea cases were patients in the V-D "stream of activity", with whom we had not made contact before and this, as mentioned above, helps to keep us abreast of the general flow of population, where more serious epidemics arise. Two per cent of our total gonorrhea case load were treatment failures. That is, they failed to respond to 1.2 million units of penicillin. This is our standard treatment for males and 1.8 million units for females given at one time and based on previous studies in our clinic showing a higher failure rate with lower dosages,¹ and also based on the idea of a curative dose of penicillin if the patient has contracted non-clinically evident syphilis with his gonorrhea. By these means follow up blood-tests for syphilis are not generally needed, although of course they are done with each admission. Before I began to keep an account of clinic activity I felt that at least 30% of our gonorrhea patients were chronic frequent repeaters within three months. However, analysis shows that only 11% returned to the clinic within three months with a reinfection, 7% within six months, and 6% within one year. Seventeen per cent were repeaters that had not been in the clinic for over a year. Again, then it appears as if our clinic load is largely a new and changing population segment.

Nine cases of chancroid were seen, 19 cases of condylomata accuminata, 24 cases of non specific urethritis, 3 cases of granuloma inguinale and 2 cases of lymphopathia venereum.

Five hundred and seventy nine persons were seen without a diagnosis of venereal disease being made, although frequently dark-field examinations, smears, and other laboratory and physical examinations were needed to rule out venereal disease.

One death due to penicillin anaphylaxis was recorded and has been reported elsewhere.² Along these lines we find ourselves doing more allergy testing for penicillin and of

Paper read at the April Meeting of the Columbia Medical Society as part of the Symposium on Venereal Disease sponsored by the S. C. State Health Department's Section on Venereal Disease and the S. C. Chapter of the American Academy of General Practice.

course we have an emergency tray for treatment of anaphylaxis always available in our treatment room. Details in reference to allergy testing and the treatment tray may be obtained from the health department.

On the epidemiological side, 735 patients, mostly females were treated for gonorrhea. Three hundred and twenty-nine or 45% were new to our clinic. One hundred and fifty, or 20% had been treated for gonorrhea within the past three months, 75 or 10% within the past six months, 65 or 9% within the past year and 116 or 16% had been treated previously in the clinic but not within the last year. It is interesting to speculate on these statistics, particularly on noting that the female three month repeaters were nearly twice as numerous as the males. Thirty-eight cases of contact to infectious syphilis were treated.

As mentioned earlier the V-D investigator is the key man in our whole program. Without him we do and will fail to carry out the necessary interviews and tracing down of the suspects and known contacts that is needed in this public health problem. Since earliest recorded history medical men have accepted the twofold purpose of curing the individual and preventing the spread of diseases to others. As a physician in private practice, I am sure I sometimes share an unfortunate general feeling that this second purpose is no longer our responsibility, whereas in effect, it is more important than individual treatment.

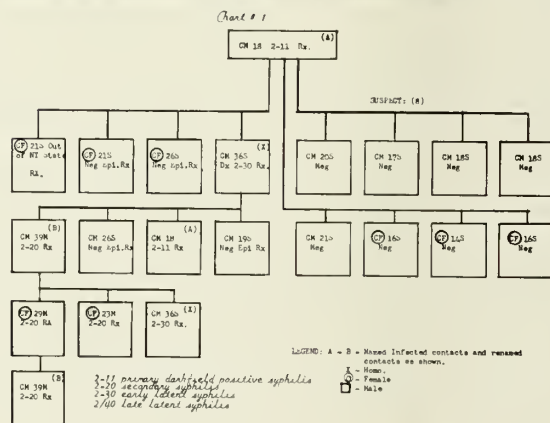
One case of venereal disease is a potential epidemic. When this fact is coupled with the realization that the great majority of venereal diseases are still treated by private physicians, we must reawaken our responsibility to treat more than the individual.

The V-D investigator is your right hand in this respect and if nothing more is gained from my presentation tonight, I hope it is to impress upon you who the V-D investigator is, and how he can help you. He is a specialist. As with all arts his has been refined to the degree that I daily gain more respect for his ability to elicit information, and more important *truthful* information, and then apply this with his knowledge of the local V-D population and situation so that cases are fol-

lowed to their logical conclusion. Where necessary, he can call on a world wide network to the extent that we have received reports of cases being brought in for treatment in Japan, the Netherlands, and Germany as well as our local cities, all from information obtained by our local V-D investigators and followed through their channels.

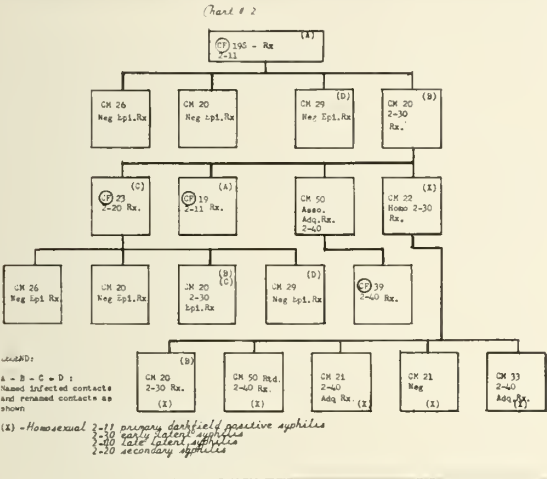
The investigator is always available to serve you and can be reached at the County Health Department. When you have a patient with syphilis or gonorrhea your call will bring him to your office, the patient's home or wherever you desire the patient to be interviewed. If you desire, all contacts can be routed through your office or handled at our clinic.

The accompanying charts will illustrate how the V-D investigator has worked in our clinic. It is particularly important to note that he is able to elicit both homosexual and heterosex-



ual contacts in tracing or working out a chain of infections. This is indeed an expert's job and one he is well qualified to perform. Chart # 1 will demonstrate this as the patient, a colored male, age eighteen had both heterosexual and homosexual contacts and had most of us tried to interview this patient for contacts, only the female contacts would have been elicited and we would have missed five cases of infectious syphilis. Chart # 2 represents a chain of syphilis that was picked up through the initiative of the investigator who made blood tests on all of the members of a circus that recently came to town. As you can see this infectious case made rapid contacts that in turn would have left our city with an

epidemic of syphilis had not the investigator been on the job. Remember one case is a potential epidemic.



The statistics, presented in the first part of this paper are being kept to give us a basic idea of what we are doing in our clinic and to give us a basic line to follow general changes, and against which modifications of treatment schedules can be instituted and evaluated. They are summarized in Table No. 1.

In closing let me remind you that our V-D clinic is your clinic and if we can serve you in any way please call on us and we beg of

you to call on the V-D investigator to help you interview your V-D patients.

Table #1
Annual Report
Venereal Disease Prevention & Control Cases
Richland County Health Department
Syphilis—Total No. Cases treated ----- 94
Early Syphilis 18

		(43% infectious)
Early Latent	23	
Late Latent	45	
Congenital	5	
Neurosyphilis	3	
Gonorrhea—Total No. Cases treated -----	925	
New Cases in our clinic	528	57%
Reinfection within 3 mo.	104	11%
Reinfection within 6 mo.	64	7%
Reinfection within 1 yr.	53	6%
Reinfection over 1 yr.	153	17%
Treatment failures	88	2%
Chancroid		9
Condylomata Acuminata		19
Non-Specific Urethritis		24
Granuloma Inguinale		3
Lymphopathia Venereum		2
Epidemiological Treatments		
Gonorrhea—total no. cases		735
Gonorrhea—new cases	329	45%
Gonorrhea—reinfection		
within 3 mos.	150	20%
within 6 mos.	75	10%
within 1 yr.	65	9%
over 1 yr.	116	16%
Syphilis		38
Interviews (observations, not infected)		579

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THE GREENVILLE COUNTY MEDICAL SOCIETY HISTORICAL SKETCHES

GREENVILLE'S ELDER STATESMAN

J. DECHERD GUESS, M. D.

No elder statesman was always such. However, even in youth he must have possessed qualities which were unusual and which portended ultimate recognition of the unusual worth of the man. Such a man was William Thomas Brockman.

Dr. Brockman's practice has extended throughout the first half of the twentieth century. He graduated in 1909 from the Medical College of South Carolina. As this is written, he is still in active practice, although at a less lively pace than formerly. He was born and reared in the Reidsville community of Spartanburg County. He attended Furman University for a time. His first practice was in Greer. He moved to Greenville in 1932.

He stood fourth in a class of forty-two at the Medical College. Being an honor graduate, he was awarded an internship at Roper Hospital. To secure an internship in 1909 was an award.

For more than thirteen years, Dr. Tom, as he was known far and wide, practiced in Greer. In almost every community smaller than a great medical center, there is one doctor who stands out above his colleagues. Such a man is so useful to his colleagues and to the community that his unusual qualities are accepted, without jealousy or acrimony. This could be said of Tom Brockman. In 1911, he went to New York to learn to do some things that were needed in Greer. This was the time of diphtheria epidemics. There was no more pitiful picture than to stand by and see a child choking to death with membranous croup, as it was called. No doctor in Greer could give aid. But laryngeal intubation was frequently life saving. Dr. Tom wanted to learn how to do intubations, and he learned.

Eclampsia was then the dread of both the doctor and patient. Experience taught that it frequently got well if the victim could be de-

livered before she was moribund. Delivery meant *accouchement forcé* and podalic version and extraction under chloroform anesthesia. Such treatment was formidable in its own right, and frequently it was deadly. Dr. Tom wished to learn a better way of treatment. Unfortunately, New York in 1911 did not have much to offer. Cesarean section was not applicable to a village and country practice isolated from hospitals and even more remote from skilled specialists.

There were other aspects of practice which demanded Tom's interest. So he stayed in New York longer than he intended, but when he came back, he was much better prepared to occupy the role of physician in chief in his territory. Within a reasonably short time, he had been called upon to intubate more than sixty children. Anticipating by many years the present day practice of performing tracheotomy on many accident cases to provide a clear airway, he intubated one accident case at Chick Springs Hospital.

He was a leading citizen as well as a leading doctor. He was active in the affairs of his church and in all civic enterprises, and he was one of the most progressive mayors Greer ever had.

So he became a great doctor, a fine citizen, a religious leader, a true humanitarian. He was recognized and accepted in each of these categories of human endeavor. Recognition gave rise to demands for counsel—not in medicine alone, but in all of the problems of life. He became a non-professional but wise and sympathetic listener and adviser. Perhaps, in the capacity of counselor, when counselors, psychologists, psychiatrists, and capable ministers were unavailable, he gave his greatest service.

Let him introduce the next phase of his professional life:

"I began to suffer from hemorrhoids. I remembered that my patients whom I had carried to my surgeon friends came away un-

This is the sixth of a series of articles, adapted from the book *A Medical History of Greenville, South Carolina*, written by the same author, and which was published by the Greenville County Medical Society in 1959.

happy. I had heard some talk of a new treatment of early uncomplicated hemorrhoids by a method of injection. In March, 1923, I sought out a proctologist in Tennessee who used that type of treatment. I was injected, and I was so well pleased with the results that I overstayed my time long enough to learn how to use the method.

"When I returned to Greer, and folks learned that I could treat and relieve hemorrhoids without surgery, my work grew so fast that I was practically pushed into limiting my work to rectal diseases."

With this beginning and with a farsighted realization that here was an opportunity to serve in a field where there seemed to be usually no other alternative than surgery (remember that hospitals were still thought of as places to go to die), Tom began making frequent pilgrimages to places of importance in proctology. He observed and studied in New York, Louisville, Detroit, Birmingham, Philadelphia, Memphis and Richmond. He spent several weeks with that former South Carolinian, Dr. Louis A. Buie, proctologist in the Mayo Clinic. Finally, with misgivings of financial failure he limited his work to proctology in 1926.

In 1927, just four years after his first interest in the injection method of treatment of hemorrhoids, Tom Brockman became an associate member of the American Proctologic Society. He became a fellow of the society in 1944. No doubt this recognition was well earned by scientific attainment alone. But there is also no doubt that his agreeable personality, the simple and somewhat childlike quality of his search for knowledge, and the implied flattery of teacher by eager pupil made Tom strong and lasting friendships among the professionally elite in proctologic circles.

Nineteen hundred and thirty-two is a year that will never be forgotten by those who lived through it. It was truly a year of financial panic. It was that year that Dr. Brockman moved to Greenville. His family was growing, he was in a new and larger community, and he was broke. In February, 1933, he operated on twenty-eight rectal cases. He collected a

meager fee from six of them and not a dollar from twenty-two.

There was some financial improvement after Roosevelt's inauguration in March. Improvement continued. In 1940, Tom was at the peak of his career, with more than 500 operative cases.

The characteristics of his personality, his eagerness to learn, his willingness to serve, and his qualities of leadership, as worthy and unusual as they were, are not what make W. Thomas Brockman a great and good man. Those things, however, prepared him for the role he was to play in professional relationships after he moved to Greenville. Before he moved, he had maintained an active interest in the county medical society. After he moved, this is what he said he found:

"During the first five or six years of my work in Greenville, I learned of a strong factionalism among the physicians. I refused to listen to men on either side and explained to these good doctors on both sides that I had spent a good part of my time in Greer persuading doctors to be friends and to cooperate with each other."

He did a fine job of persuading and reestablishing friendships in Greenville. He influenced the younger men who had come in earlier and the new ones, as they came to Greenville, not to align themselves with any one faction but to be friendly with all factions. Several of the older men who could not forget or forgive real or fancied wrongs continued to hold themselves aloof from each other. However, in those instances, time did finally what Tom could not do. Greenville has been outstandingly and remarkably free from factionalism, professional cliques, and uncomplimentary professional gossip for many years. It has maintained a fine professional atmosphere for a quarter of a century. This, in turn, has attracted outstanding young specialists to locate here and has made of Greenville the medical center which it is today. To many, that seems to be the core of the contribution which Tom Brockman has made to Greenville medicine.

In 1937, Dr. Brockman was elected president of the county society. The society was

ready for his leadership. He suggested and engineered the launching of *The Bulletin* of the society and of an ambitious program of meetings with speakers selected from the great medical teaching centers. The policy of programs of seminar quality has continued, and it no doubt was ultimately responsible for the seminars of the Greenville General Hospital staff, which were begun three or four years ago.

During the World War II years, Dr. Brockman spent much time and energy in selling a statewide Blue Cross plan to South Carolina doctors and to members of the State General Assembly. He preached everywhere that Blue Cross was the best defense against federally regulated socialized medicine.

In 1944, Dr. Brockman was selected by his county society to be a candidate for the position of president-elect of the South Carolina Medical Association. The following was published in *The Bulletin* after that action was taken:

"From a field of four likely men, the members of the Greenville County Society unanimously selected Dr. Tom Brockman to be its candidate for the position of president-elect of the South Carolina Medical Association. His selection was a compliment to him, but it was a well deserved one. There is no more sincere friend to organized medicine than he. There is no one who has displayed broader vision, or more initiative or more energy in carrying out plans and programs than he. He was president of the Greenville Society five years ago. It was under his leadership that *The Bulletin* was founded. He it was who started the society on its program of meetings of statewide interest and of a character so educational that if one attended them for a year, he had had an excellent refresher course in medicine. While he was president, and since, many old scars of enmity and misunderstanding have healed, and the members of the society are annealed into a true fraternity, all working together in harmony for the good of the society and for Greenville's medicine. He, personally, with tact and great understanding brought enemies together. It was a great study in the art of leadership to watch him work.

"And when his term of office was over, he did not rest on his laurels, but instead he has continued the great work which he began.

"Not so polished as some but he is more sincere; not so learned but that he seeks to learn; not a great orator, but a forceful speaker; not so handsome, perhaps, but his large, vigorous physique inspires one with confidence in his powers of leadership."

Dr. Brockman was elected President-Elect of the State Association without opposition. He became president in 1945. He was a war president and he served well in those trying days.

The government allowed a resumption of conventions in 1946. As a compliment to the president from Greenville, the Greenville County Society requested that it be allowed to act as the host of the State Medical Association in its annual convention to be held at Myrtle Beach. The invitation-request was granted. It seemed to be and surely was a great convention in every way.

Dr. Brockman has said regarding the limitation of his practice to proctology, "It required lots of courage to give up a growing general practice and take on a new specialty not so favorably regarded by the medical profession. I was the pioneer all-out proctologist in South Carolina, and we could include North Carolina and Georgia. Several men in Atlanta and in Columbia did some rectal work, but I was the first to give all my time to rectal diseases in these three states and at the same time to maintain an ethical standing in my medical society."

When Tom Brockman was asked recently what phase of his many activities gave him the most pride, he said:

"I am proud that I was able to establish myself as a proctologist, a specialty which in 1923 was not in good repute in organized medicine, and at the same time retain my place in the Greenville County Society. I am proud to be the first South Carolinian to be made first a Fellow and then a Diplomate of the American Proctologic Society. I am proud to have represented my own state on the Council of the Southern Medical Association from 1950-1955. And I am proud of the honor that was given me by the American Proctologic

Society in April, 1957 in recognition of thirty-one years a member. The courtesies were simple, but they came from the elite of the fellowship of the society and from their hearts.

"However, I feel that the finest work of all that I have done in my forty-nine years in the practice of medicine has been the success that I have obtained in organized county society medicine. All of us know that the county society is the basis of the State Association and of A. M. A. There is no way to estimate how much good one individual can do for his county society and his state medical association by cultivating and developing friendship, respect and confidence in each other among the membership.

"I believe (he continued) that the Greenville Society is the finest example of this fellowship and good feeling of its members. Various members of the State Medical Association have told me over and over that they feel that the Greenville Society has less friction and factionalism in it than any other county society. I feel that the State Association

is better united now than it has ever been before."

So that is Tom Brockman, a man who though still living, has become almost a tradition, a man whose life has influenced the lives of all members of the Greenville County Society throughout half a century, and a man whose good influence shall continue long after he is gone. He is truly Greenville's elder medical statesman.

And when at last his plea for fraternal love and peace and his quest for further knowledge are carried to a distant shore, may it be said of him:

"Of no distemper, of no blast he died,
But fell like autumn fruit that mellowed long,—
Even wonder'd at, because he dropp'd no sooner.
Fate seemed to wind him up for four score years,
Yet freshly ran he on ten winters more;
Till like a clock worn out with eating time,
The wheels of weary life at last stood still."

MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

Ventricular Aneurysm

DALE GROOM, M. D.
Dept. of Medicine

Case Record—A presumptive diagnosis of ventricular aneurysm was made on the basis of the electrocardiograms of this case plus the history of a massive myocardial infarction followed by cardiac enlargement, intractable congestive failure and the presence of a prominent gallop rhythm. It was confirmed by fluoroscopic examination which revealed an area of paradoxical pulsation of the left ventricular wall near the cardiac apex.

The patient was a 54 year old retired executive, a diabetic whose heart was known to have been of normal size prior to his infarction five months previously. Unusual features of his attack were that he had experienced remarkably little chest pain in

the face of extremely high values of serum transaminase, his blood pressure had remained low and the pulse rate high, and profound weakness, dyspnea and edema had persisted for months thereafter despite digitalis and diuretic therapy. Unless he remained at bed rest he quickly developed edema, ascites and engorgement of the liver and neck veins. Quinidine and potassium were used for control of numerous ventricular ectopic beats.

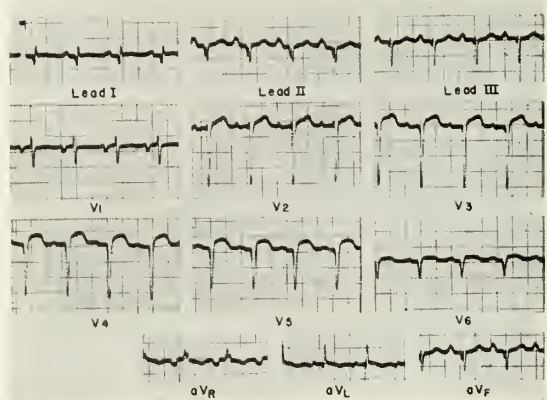
Chest roentgenograms showed pulmonary congestion and moderate enlargement of the left ventricle without, however, any discrete area of bulging of the ventricular wall. During several months of observation his electrocardiogram remained essentially unchanged from this one, recorded six months after the myocardial infarction.

Gross impairment of his cardiac reserve was demonstrated by catheterization studies^o which indicated a resting stroke volume of 32 ml. and cardiac output of 3.75 liters per minute, increasing to only 38 ml. and 4.93 liters after mild leg exercises. Pressure

in the pulmonary artery was more than double the normal value of 20 to 25 mm. of mercury, probably due to his protracted congestive failure.

The patient was operated on^o for ventricular aneurysm with utilization of a pump-oxygenator for temporary cardiopulmonary bypass. Occlusion of the left coronary artery appeared to involve both circumflex and descending branches. As visualized from within the left ventricle, the aneurysm extended anteriorly from the apex onto the septum and contained a small organized thrombus attached to the endocardial surface. Ventriculoplasty was performed with excision of a crescentic 7 x 4.5 cm. section of the aneurysmal wall which measured approximately 0.7 cm. in thickness. Microscopically the excised specimen consisted mainly of hyalinizing fibrous tissue with only vestiges of cardiac muscle remaining.

Two months after the ventriculoplasty the patient was able to resume limited physical activity without recurrence of congestive failure. A repeat chest roentgenogram showed a 3 cm. decrease in the transverse diameter of the heart. His electrocardiogram was essentially unchanged except for diminished elevation of S-T segments (maximum of 1 mm.) in the precordial leads.



Electrocardiogram—There is a sinus tachycardia, regular at a rate of 110. The P-R interval is a little less than 0.20 and the QRS about 0.06. Voltage of the QRS complexes is moderately low in the limb leads, especially for an enlarged heart.

In all the left precordial leads, from V₃ through V₆, R waves are completely absent, indicative of an anterolateral infarct, possibly transmural. The 2-3 mm. elevation of S-T segments in these leads was a consistent finding in all his pre-operative electrocardiograms.

Deep Q waves are present in lead I, compatible with anterior infarction, and the small Q of aVF suggests some extension onto the inferior wall of the left ventricle. Lead AVR has the normally inverted P and T waves but its QRS is upright and notched instead of the usual negative deflection.

Discussion—This electrocardiogram is typical of

anterolateral infarction which, because of the elevation of S-T segments, one would assume to be acute. However, persistence of the S-T displacements for months after his documented attack of myocardial infarction, and without the changing T waves usually associated with an acute process, is strongly suggestive of ventricular aneurysm. The physical findings, intolerance to exercise, and clinical course of this patient are entirely in keeping with that diagnosis which was confirmed by the fluoroscopic observation of paradoxical pulsation in an area of the lateral wall of the left ventricle.

At one time the term "cardiac aneurysm" was applied rather loosely to almost any type of enlargement of the heart. Its present meaning implies a localized dilatation, usually of a portion of one of the ventricles, almost always the result of previous infarction of that area. A more specific term for this is ventricular aneurysm. The weakened, necrotic or fibrotic area of myocardium may protrude out in a fixed bulge which is evident on a chest roentgenogram or it may protrude only during systole in an outward, "paradoxical" pulsation as the remainder of the cardiac border moves inward. The question of what degree of bulging constitutes an aneurysm is a semantic one but, from a mechanical point of view, when part of the ventricular wall not only fails to contract but actually gives way on systole, contraction of the remaining viable myocardium is rendered less effective and the stroke output is reduced. There is an obvious clinical justification for this concept of ventricular aneurysm.

The incidence of this complication of coronary disease depends of course upon one's criteria for diagnosis but doubtless significant degrees of aneurysmal dilatation occur much more frequently than suspected. Even at autopsy the lesion may be readily overlooked because there is no intraventricular pressure to distend it. Ventricular aneurysm is said to be much more frequent among patients with hypertension and diabetes (as, of course, is coronary disease), and particularly among those who have "silent" infarcts (those unaccompanied by severe pain, or unrecognized and hence untreated). Presumably, failure to provide adequate rest and care at the crucial time of necrosis, organization and scar tissue formation might be more apt to result in a weak, bulging scar, as would a very large area of infarction, especially one which is transmural or one which is distended by an abnormally high intraventricular pressure. The consequent reduction in cardiac output is reflected in lower blood pressure, tachycardia and congestive failure. A further complication may ensue with formation of a mural thrombus within the aneurysm, giving off emboli to the systemic circulation.

When the aneurysm is located on the anterior or lateral ventricular wall the significant ECG abnormalities are mainly in the precordial leads and consist typically of persistent elevation of S-T segments with, of course, evidence of previous infarction. Prominent R waves in aVR are said to be a com-

mon finding. Visualization of the localized area of paradoxical pulsation often requires careful fluoroscopic examination of the heart in multiple oblique projections (although a possible counterpart of this may sometimes be seen and felt on the precordium as a systolic impulse separate from that of the apex). The protodiastolic gallop, an accentuation of the third heart sound, is common to this as well as other types of left ventricular dilatation and failure. The diagnosis is more difficult when the aneurysm is situated on the posterior or inferior wall because it is not so well visualized roentgenographically. Moreover, though analogous ECG abnormalities have been reported in leads facing aneurysms on the posterior

or inferior wall, these leads are not comparable in localization to the precordial leads for the anterior wall. The mechanism of persistence of the S-T displacements for months or years in this disease—far longer than would be expected of a current of injury—is unknown.

With the advent of surgical procedures for repair of ventricular aneurysm, its diagnosis assumes a new importance.

* Catheterization studies by Dr. Edward Dennis and
** surgery by Dr. Denton Cooley, both of Baylor University, to whom I am indebted for detailed reports on this case.

Treatment of tinea pedis with griseofulvin. George Prazak, Colonel M. C., John S. Ferguson, Captain, M. C., James E. Comer, Captain M. C. and Betty S. McNeill.

Ninety-two patients with tinea pedis were treated with varying doses of griseofulvin and 63 of these were felt to have had sufficient treatment and observation to be used in this study. Twenty-five of the 63 patients were considered cured clinically and by laboratory findings. Of the cures, 9 were patients who received both oral treatment and topical application utilizing Whitfield's ointment and pHisoHex scrubs. Each of the latter 9 cases had been failures on oral treatment alone. A total of 13 patients have thus far been treated with combined oral and topical therapy and of these 13, the 9 mentioned above are cured. All patients receiving the combined treatment have shown much more impressive clinical improvement. All patients treated with griseofulvin in any dosage have responded clinically with marked diminution of pruritus and reduction of scaling. However, 15 of the 50 cases not receiving topical therapy have shown clinical relapse on discontinuance of the oral therapy. The treatment of choice consisted of 250 mg. given four times daily with topical preparations as indicated above, and for a duration of three to four weeks. Side effects seen were mainly headache and gastro-

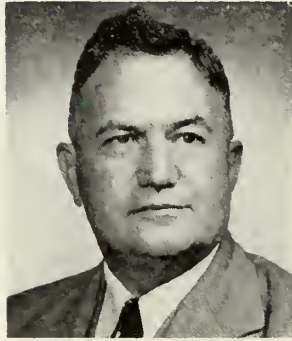
intestinal distress but one each of the following were seen: serum sickness, generalized morbilliform eruption, albuminuria and leucopenia (3,600).

One-year experience in the treatment of dermatomycoses with griseofulvin. V. Pardo-Castello, M. D., Havana, Cuba.

More than 100 cases of dermatomycoses have been treated with griseofulvin since November 11, 1958, the dosage being an average of 1 gm. daily for adults and 500 mg. for children. The drug was well tolerated by the majority of patients. There was one case of morbilliform rash and several of gastrointestinal disturbances and of headaches. In only a few cases the drug had to be discontinued.

Clinical and mycological results were excellent in the great majority of patients. However, there were a number of relapses and of reinfections; some due perhaps to the discontinuation of the drug too soon, some to lowering the daily dose below the parasitostatic level and also undoubtedly to reinfection from shoes, socks and clothing.

Tinea of the scalp, tinea circinata and onychomycoses are usually definitely cured if treatment is continued long enough. Most relapses have been observed in cases of tinea cruris and of dermatophytosis of the hands and feet.



PRESIDENT'S PAGE

FREEDOM OF CHOICE

Here's wishing all members of the South Carolina Medical Association and the Citizens of our State had a Merry Christmas, and will enjoy health, happiness and prosperity during the New Year.

1. "The American Medical Association believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses."

2. "Each individual should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care, and the American Medical Association vigorously supports the right of the individual to choose between these alternatives."

These paragraphs were indoctrinated by the House of Delegates in June 1959. A third paragraph was added in Dallas in December, 1959, in order to clarify our understanding of their choice of physicians.

3. "Lest there be any misinterpretation, we state unequivocally that the American Medical Association firmly subscribes to freedom of choice of physician and free competition among physicians as being prerequisites to optimal medical care. The benefits of any system which provides medical care must be judged on the degree to which it allows of, or abridges, such freedom of choice and such competition."

The theme is that regardless of association with an industry, manufacturing plant, public carrier (railroads, busses, aeroplanes, taxi companies) which might employ a physician or physicians, if the individual does not wish to have one of their group attend him or her, the persons may have whom they choose provided he is a member in good standing of the American Medical Association. It even states that the patient may change medical doctors at will if not satisfied. It also insinuates that mothers should have the right to choose the medical doctor of their choice for their offspring.

The freedom of choice of physicians must be applied not only to the people as our patients but also to the doctors themselves. Let's all pull together, use our knowledge of the medical sciences to the best of our ability, and practice the true art of medicine.

William Weston, Jr., M. D.
President

Editorials

A MEDICAL HISTORY OF GREENVILLE COUNTY

The present day rapidity of medical progress in no way lessens the need for knowledge of the events of the past which led up to today's developments. This idea is acceptable to all thinking people, although a relatively small number of the members of our profession show any great interest in the history of medicine. This is unfortunate at a time when not only the practices and techniques of medicine are changing daily, but also the whole relationship of medicine to society and the whole outlook of society on medicine.

Dr. Decherd Guess of Greenville has long been interested in medical histories and particularly in the history of his own city. He has composed a history of Greenville County which is a valuable addition to the medical history of the State. Already some chapters of this History have appeared in this *Journal*, and now the completed volume comes from the press at Greenville in a pleasing form and an interesting content.

This book takes up not only the story of the prominent individuals of the area, but also traces the trends and changes which have come to pass over the last hundred and fifty years or so. Dr. Guess has a gift with pen, and a faculty for selecting apt quotations so that the combination makes a most readable story which should be of interest to all of us in the State, and in fact in much wider circles, since the history of any large area must be composed of the histories of its smaller units.

Dr. Guess deplores along with others the passing of the "giant" in medicine and compares current regretful statements that the whole age lacks heroes. Some of this change he attributes to the elevation of ability in training above its former level. He ends with this word:

"No one of us may be a giant topping our fellows. However every doctor who places the good of the patient above every other consideration and especially above personal

profits and personal convenience; who sincerely tries to keep pace with the advancement of medical science and practice within his field; and who finds time to explore the apprehensions and worries of his patients and give opportunity for their aeration, such a doctor will be a great and good physician."

THE DOCTOR IN PUBLIC AFFAIRS

At the meeting of the American Medical Association in Dallas last December, Dr. Louis Orr, President of the Association, emphasized the fact that doctors cannot pass their political responsibilities to others. He warned that if the physician valued his nation's high standard of medical care, he must not ignore the social, economic and political issues which affect the practice of medicine. He stated that politics was an activity which called for the concern and contribution of the highest type of citizen, as the doctor is generally esteemed to be.

He also urged that we physicians be concerned with explaining the stand of medicine in matters related to the general public, that we be positive in our approach rather than always in opposition to something. He said that in only one instance did the AMA actively oppose current legislation, that is in the case of the Forand Bill, which was considered by all medical authorities completely unsound.

In South Carolina doctors take very considerable parts in civic and community activities. It is not unlikely that they could do much more to participate in affairs that concern them as well as the next citizen. The doctors have also made the beginning of an effort to bring before the public a better knowledge of the concerns and activities of medicine in organized form, and it is anticipated that this activity will be pursued more and more as time passes. Certainly we are all subject to many misunderstandings on the part of even our good friends, and anything that we can do to make matters clearer and obviously above-

board will react to the benefit of the whole profession as well as the country as a whole.

THE INDEX

The Index which appeared in the December 1959 issue of the *Journal* was compiled almost entirely by the efforts of Miss Elizabeth Williams of the Library of the Medical College of South Carolina. Miss Williams has been good enough in the past to work with the *Journal* in the preparation of a proper Index, and it is the feeling of the editor that there has been a tremendous improvement in the status of this necessary department of the *Journal*. The Editorial Board wishes to acknowledge its indebtedness to Miss Williams, and to bespeak her continued interest in this activity.

ASSOCIATION'S TELEVISION PROGRAM

The initial program selected for the series of television shows sponsored by The South Carolina Medical Association known as "House Call" is based on "Care of the Aged". This program appeared in Greenville on WFBC-TV on November 22. The following doctors participated: Dr. John Fewell, Dr. Leon Marder and Dr. George Wilkinson, Jr. The same program has been placed on video tape at WUSN, Channel 2, Charleston and was presented in mid-December. The doctors participating were Dr. George Durst, Dr. Charlton deSaussure and Dr. Robert Wilson. It was arranged to have an announcement story on the series in the *Charleston Evening Post*.

This theme will also be developed on programs on WIS, Columbia, WSPA, Spartanburg and WRTW, Florence. Tentative scheduling places these programs in January. It is anticipated that shows will be established on a regular monthly basis on all five stations by February.

The following topics have been considered

—suggestions for others are welcomed by the Public Relations Consultant: Food Faddism; Cancer, Related Research and Treatment; Rising Costs of Hospital and Medical Care; Heart Disease, Related Research and Treatment; Why Medicine is Organized.

The doctors on the programs will serve as their own authorities on scientific matters and the consulting agency will endeavor to have members of the Cancer Society and the Heart Association on the programs concerning these particular fields, and will furnish outlines of scripts which may be modified by the participating physicians. This is in line with AMA's official policy of cooperating with other interested groups.

HAPPY NEW YEAR?

Under the title "A dim view", the following editorial gives thought for gloom—

"It hardly can be disputed that the United States is suffering from numerous ills. Thoughtful citizens, asked to sum up the state of the union, are likely to produce statements that contain little cheer.

One exceptionally gifted and candid American has made such a statement. He is George F. Kennan, former U. S. Ambassador to Russia. Speaking recently in Washington, Mr. Kennan said:

"If you ask me—as a historian, let us say—whether a country in the state this country is in today, with no highly developed sense of national purpose, with the overwhelming accent of life on personal comfort and amusement, with a dearth of public services and a surfeit of privately sold gadgetry, with a chaotic transportation system, with its great urban areas being gradually disintegrated by the headlong switch to motor transportation, with an educational system where quality has been extensively sacrificed to quantity, and with insufficient social discipline even to keep its major industries functioning without grievous interruptions—if you ask me whether such a country has, over the long run, good chances of competing with a purposeful, serious and disciplined society such as that of the Soviet Union, I must say the answer is no."

"This is a pessimistic view. But the glaring national faults which Mr. Kennan cites do not provide a basis for optimism."

Charleston News and Courier

MINUTES OF COUNCIL MEETING

A special meeting of Council was held at the Columbia Hotel on October 7, 1959. The meeting was called to order at 2:40 p. m. by the Chairman, Dr. Charles Wyatt. Members present were Drs. Cain, Evatt, Stokes, Wilson, Waring, Johnson, B. Smith, Burnside, Fleming, Gressette, Perry, Crawford, Scurry, Brewer and Mr. M. L. Meadors.

The minutes of the several meetings of Council held in May 1959 during the Annual Session of the State Association in Columbia were approved as published.

The Chairman announced that the first order of business would be the consideration of a request from certain radiologists in Spartanburg County, now concerned in a suit-at-law, to direct the Counsel of the Association, Mr. M. L. Meadors, to file a brief as a friend of the court. Mr. Meadors gave a resume of the litigation, the ruling of the Attorney General, and the request of the plaintiffs. Drs. Fleming and Johnson of Spartanburg County gave further information regarding the situation, after which a general discussion ensued.

It was then moved by Dr. Gressette that Council direct the Counsel to file a brief as a friend of the court in support of the radiologists, pointing out that the institutions cannot engage in the practice of medicine, that individual physicians should make charges directly for professional services, and that the institutions should make other charges to the patient for their cost in rendering such service. After some further discussion this motion was unanimously adopted.

Dr. Clay Evatt then reported for the Insurance Committee and presented an office overhead policy, which was approved. He then presented a proposal for a high limit accidental death policy, which was likewise approved. The Executive Secretary was directed to write a letter to the insurance broker notifying him of this action, which could be used in their prospectus for these policies.

Mr. Macon P. Miller and a delegation representing the South Carolina Chamber of Commerce appeared before Council regarding the proposed fee schedule for compensation cases. It was pointed out that the average payment to physicians in South Carolina was substantially higher than in either North Carolina or in Georgia, and it was further pointed out that the number of such cases in South Carolina was considerably lower than the total number of compensation cases in North Carolina. This matter was referred to a special committee of Council for further study, to consist of three members appointed by the Chairman and to meet and consider the matter in conjunction with a committee from the South Carolina Chamber of Commerce. The Chairman appointed Dr. J. P. Cain, Chairman of this special committee to serve along with Dr. J. Howard Stokes and Dr. R. L. Crawford.

A letter from Dr. William H. Prioleau, Chairman of the Program Committee in regard to honoraria for speakers was read and received as information.

It was announced that the Annual Meeting of the Association would be held in Myrtle Beach, S. C. on May 17, 18, and 19, 1960. Council approved the modified American Plan offered by the Ocean Forest Hotel, the daily charges to include breakfast and the evening meal but not the midday meal.

Dr. Bachman Smith made a suggestion regarding the Annual Association Meeting, to the effect that reference committees meet immediately after the adjournment of the House of Delegates, at approximately 5 p. m., so that the evenings would be free. He also suggested that a President's breakfast be held at 9 a. m. Thursday morning and at this time the Annual Address of the President and the report of the Memorial Committee be presented, to be followed later by the beginning of the Scientific Session. These matters were referred to the Program Committee.

It was announced that the special committee to meet with Dr. Whitten and consider his problems regarding the Whitten Village was to consist of Dr. George Wilkerson, Chairman, Dr. D. L. Smith, and another member to be named by these two physicians.

It was then pointed out that the various committees authorized by Council for the Blue Cross and Blue Shield Plan in each district had not yet been completed, and the Councilors from the various districts were asked to complete this assignment as soon as possible.

Dr. George B. Johnson, Delegate to the A. M. A., reported that a number of the Southeastern states had been asked to act as joint hosts along with Florida for the Annual Meeting of the American Medical Association to be held in Miami in 1960. Dr. Johnson requested an appropriation for \$500.00 for entertainment purposes during this meeting, and this request was granted.

It was announced that the Law-Science Institute was to hold a symposium in Charleston on March 21-22, 1960; this was approved and endorsed provided it met with a like action from the Charleston County Medical Society.

Mr. M. L. Meadors was then elected Executive Secretary for 1960 and Dr. J. I. Waring was elected Editor of the Journal for the year 1960.

The budget was adopted for the calendar year 1960. (Budget printed in November 1959 Number of *The Journal*.)

Dr. J. I. Waring then reminded the Council that it had been the policy to send the Journal to all Senior Medical Students and all members of hospital resident staffs in approved hospitals throughout the state and if Council approved he would continue this policy. It was approved.

Dr. Waring reported on the progress of the program for Public Relations, and announced that six TV Programs had been arranged to be broadcasted in several different parts of the state, with programs devoted to the problems of the aged and various other health problems.

Dr. Wilson suggested the possibility of the State Medical Association appointing a panel of specialists

for help in malpractice cases. No action was taken on this but it was pointed out that the Councilor in each district had been directed to set up such individual committees.

Mr. M. L. Meadors announced that a bill requiring hospitals to furnish records to certain authorized persons was to be brought up in the legislature. This was referred to the Legislative Committee; it was the concensus of Council that no opposition to this bill be offered.

A suggestion that *Today's Health* be sent to all members of the State Legislature, all Congressmen, and the two United States Senators was approved and the Executive Secretary was directed to send a one year's subscription to this magazine to all of these individuals.

Dr. J. P. Cain noted that the President of the Association was Ex-officio Chairman of the Medical Department for Civilian Defense, and he thought that a permanent Chairman for this position was a much

wiser plan to follow. Dr. Wyatt, former Chairman, was likewise in favor of this course, and pointed out that the Chairman should certainly live in or near Columbia. It was pointed out that this matter had been approved by a resolution of the House of Delegates, and that the President was authorized to appoint a deputy to act in his stead.

Dr. Gressette reported that it was his understanding that the American Association of Nurses had announced their support of the Forand Bill. The Chairman of Council was directed to appoint a Committee of three to confer with officers of the State Association of Nurses in this regard, and to inform them of the stand of the Medical Association in respect to this bill.

There was no further business and Council adjourned at 6 p. m.

Respectfully submitted,
Robert Wilson, M. D.



BLUE CROSS . . . BLUE SHIELD



Dissatisfactions with the assignment of benefits under Blue Cross contracts arise usually from a lack of familiarity with the coverage provided by the several contracts or from a failure of a contract to provide more completely for various diagnostic procedures, including those relating to recognized illness, those which are a follow-up, and those of a more or less routine character.

It would be fine if one's desires and one's inclination could determine the extent of insurance coverage. However, that can never be. It would be too costly to receive support. There would continue to be excessive and unnecessary utilization. There would continue to be instances of selfish desire to recover in services, whether needed or not, all that had been expended for the insurancee.

The following letters deal with irritating problems which have come up in administering claims. They are illustrative of the continuing effort which is made by the Plan to clarify contract coverages.

Dear Doctor:

It would be fine if we could concur in your opinion that "most doctors do not abuse the insurance benefits due his patients and that very little, if any, unnecessary diagnostic work is done." We have learned differently from an extensive experience. Actually, the statement as you made it is really two statements; namely, the first refers to abuse, which we refer to as overutilization or misutilization; the second refers to diagnostic studies, in relation to insurance coverage.

All over the country, there is too much hospitalization, unnecessary hospitalization, too long hospitalization, and hospitalization in order to have diagnostic studies of various kinds made—mostly by x-ray. In the case of hospital admissions primarily for x-ray studies, no fault is found by Blue Cross with the fact that such studies are made. (My personal feeling is that entirely too much diagnostic x-ray exposures are made, too often with little or no indications and too often repeated, again with little or no indications. Several x-ray men share my view. But that is not an insurance matter.)

The complaint directed at Blue Cross is based upon the fact that Blue Cross contracts provide very minimal benefits for hospital admissions primarily for x-ray and other diagnostic studies. Although that is the case, many admissions are for that purpose—hospital admissions for studies which could be done equally as well on an out-patient basis. That fact in turn is not the concern of Blue Cross, although it serves to increase the costs of medical care, per se; it makes more hospital beds necessary in any given community, at a tremendously unnecessary cost to the taxpayers who build the hospitals, and it removes maintenance and operation costs of x-ray laboratories from the area of private enterprise to that of public facilities.

What concerns Blue Cross is that such unnecessary admissions are made with the expectation or the hope that Blue Cross will grant hospital benefits. The hope may be based on lack of understanding of the extent of insurance coverage. This may apply to

the doctor, to the patient, or to both. The hope is frequently encouraged by various subterfuges: admissions with a legitimate diagnosis, but with x-ray examinations ranging far afield from that diagnosis, and so often with a hospital stay so short that the true reason for admission is indicated. Rare it is that the doctor indicates on the hospital chart, that admission had been made primarily for diagnostic studies of various kinds. Equally as rare is it, after the Claims Department has studied the case, using hospital records and at times other sources of information, and has concluded that admission was primarily for diagnostic study, or that various diagnostic studies had been made, which had no reference to or connection with the primary reason for hospitalization, that the doctor does not request a reversal of the ruling against allowing benefits. At times this is done pleasantly and in a spirit of co-operation. More often it is done in anger, and rudely, and often insultingly. It is remarkable how often the request for a review of a case shows a complete lack of understanding of the provisions of the contract.

On the basis of your statement that the barium enema was indicated in ascertaining the nature of an acute illness, I have advised that benefits for it be allowed. Note, I say advised. I do not have the power to make a ruling or to instruct, even though a clerk frequently states that I have "ruled."

X X X

Dear Sir:

Thank you for your letter addressed to the Plan. It has been referred to me for reply.

First, let me say that our use of the terms "diagnostic care" and "diagnostic admission" are unfortunate. They crept into usage because they are short, and we thought at first, easy to understand. We are trying to eliminate them from our vocabulary, because our subscribers and many of our doctors do not seem to understand them.

"Hospital service" is defined in Article I of the Subscription Agreement. Assuming the limitations therein referred to (one of these is in Article III, Section B, Paragraph 2) hospital service is hospital care to members who are bed patients. That means patients who are necessarily or wisely bed patients, in contradistinction to ambulatory patients. The primary purpose of Blue Cross is to furnish hospital service as so defined and limited.

However, to meet a demand, a special type of hospital service is provided. Benefits are minimal. This special service is defined in Article III, Section B, Paragraph 2. It says: "For admissions . . . primarily for diagnostic studies, x-ray examinations, laboratory examinations, basal metabolic tests, or electrocardiograms, South Carolina Hospital Service Plan will provide an allowance against the hospital bill. . . as follows: Up to \$10 for the first day of hospitalization. . . etc."

You can readily see how it came about that in our parlance such admissions came to be called "diagnostic admissions." The things referred to are diagnostic

procedures, just as counting the pulse, taking the temperature, or listening to the heart sounds are diagnostic.

Actually, the examinations referred to are often made in the x-ray doctors' office away from the hospital. Now most of our x-ray laboratories are in hospitals.

With regard to your case. You entered the hospital at 4:55 P. M. one afternoon. You had the x-ray examination the next day. You left the hospital on the morning of the third day.

It appeared to us that you were sent to the hospital primarily for x-ray examination. If that be true, you very properly received credit of \$18 on your hospital bill. (The day of admission and day of discharge count as one day.)

You probably would have understood this better if we had simply said that it seemed that you were admitted primarily for x-ray examination.

X X X

Dear Doctor:

Your letter to me and a copy of our Mr. Masters' letter to your partner have both been read carefully, and frankly I cannot understand just what is the cause of your anger, if that is the right word. The only clue I find is your statement, "I can definitely assure you that neither the patient, the family nor his physicians had any idea that the situation was present on February 1, when the Dread Disease Endorsement went into effect."

That statement seems to imply that either Mr. Masters or I had charged, suspected, or believed that some one of you knew of or suspected the presence of cancer on February 1. Mr. Masters certainly made no such insinuation on his own. If his letter carried that idea, it was contained in his statement of my opinion of the case. That opinion was that the condition must have already been present on February 1 — not that any one concerned knew of its presence. Because of the melena which was discovered on March 5, it was to be believed that the primary condition had been present at least one month previously. Your partner said almost the same thing in his report. He wrote: "In retrospect, his first sign of carcinoma was about March 5, 1959 when melena was discovered."

My note written on the endorsement, in disapproving benefits, was: "Melena—March 5, 1959—one month after effective date of endorsement. Bleeding in any malignancy is always a relatively later symptom. Therefore, the condition must have already begun on February 1, 1959, the effective date."

So many people including intelligent doctors fail to differentiate in their thinking the principle "Pre-existing" and that of knowledge of pre-existence, which are two very different things. The Boards have changed the wording of the requirement for a waiting period for pre-existing conditions in the contract so that it now reads: "Article II, Section C: For any abnormal physical condition, ailment or disease, whether

it be known or unknown to the member, which may be considered from a medical standpoint to have been present in any form on the effective date of the contract, or for any complication which may arise therefrom. . ." This was done to combat the existing confusion.

Our Dread Disease Endorsement is not so detailed or explicit, but its intent is the same. It says in Article II: "The amendment makes available bene-

fits. . . for specified illnesses to members who contract any of the following diseases, *after* the effective date of this rider. . ."

I sincerely hope that I have clarified the issue. I am delighted that you wrote me as you did, and I appreciate your restraint. Many of my friends are not so considerate nor so self-controlled.

J. Decherd Guess, M. D.

Medical Director, Blue Cross and Blue Shield

The South Carolina Medical Association urges you to

FIGHT FOR AND

Send a handwritten letter to your congressmen and any others who may have a voice or a vote.

ACTIONS OF THE HOUSE OF DELEGATES AMERICAN MEDICAL ASSOCIATION THIRTEENTH CLINICAL MEETING DECEMBER 1-4, 1959 DALLAS, TEXAS

Freedom of choice of physician, relations between physicians and hospitals, a scholarship program for deserving medical students and relative value studies of medical services were among the major subjects acted upon by the House of Delegates at the American Medical Association's Thirteenth Clinical Meeting held December 1-4 in Dallas.

Speaking at the opening session of the House, Dr. Louis M. Orr of Orlando, Fla., A.M.A. President, urged the nation's physicians to take a more active interest in the whole area of politics, public affairs and community life. Dr. Orr also asked physicians and medical societies to do a more effective job of telling medicine's positive story, adding that "if more people knew more about the things we support and encourage, they would listen to us much more carefully about those occasional things that we oppose."

Two nationally known political leaders from Texas also addressed the Tuesday morning session. Senator Lyndon B. Johnson, majority leader in the U. S. Senate, called for a "politics of unity" which will enable Americans to exert strength and determination in an effort to create a world in which all men can be free. Speaker of the U. S. House of Representatives Sam Rayburn urged greater attention to the task of educating young people in the principles of American government and giving them a desire to perpetuate it.

FREEDOM OF CHOICE

In considering four resolutions which in various ways would have changed or replaced the statements on freedom of choice of physician which the House adopted in June, 1959, when acting upon the recommendations in the report of the Commission in Medical Care Plans, the House reaffirmed the following two statements approved in Atlantic City:

1. "The American Medical Association believes that free choice of physician is the right of very individual and one which he should be free to exercise as he chooses."

2. "Each individual should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care, and the American Medical Association vigorously supports the right of the individual to choose between these alternatives."

However, in order to clarify and strengthen its position on the issue of freedom of choice of physician, the House also adopted this additional statement which was submitted as a substitute amendment on the floor of the House:

3. "Lest there be any misinterpretation, we state unequivocally that the American Medical Association firmly subscribes to freedom of choice of physician and free competition among physicians as being prerequisites to optimal medical care. The benefits of any system which provides medical care must be judged on the degree to which it allows of, or abridges, such freedom of choice and such competition."

PHYSICIAN-HOSPITAL RELATIONS

The House received 12 resolutions on the subject of relationships between physicians and hospitals. To resolve any doubt about its position, the House did not act upon any of the resolutions but instead reaffirmed the 1951 "Guides for Conduct of Physicians in Relationships with Institutions." It also declared that "all subsequent or inconsistent actions are considered superceded."

The House also accepted recommendations that (1) the House of Delegates acknowledge the need to strengthen relationships with hospitals by action at state and local levels, (2) the Board of Trustees of the Association continue to maintain liaison with the Board of Trustees of the American Hospital Association, and (3) the Council on Medical Service review this entire problem to ascertain if there have been actions inconsistent with the 1951 Guides.

Those Guides summarize the following general principles as a basis for adjusting controversies:

"1. A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee.

"2. Where a hospital is not selling the services of a physician, the financial arrangement if any between the hospital and the physician properly may be placed on any mutually satisfactory basis. This refers to the remuneration of a physician for teaching or research or charitable services or the like. Corporations or other lay bodies may provide such services and employ or otherwise engage doctors for those purposes.

"3. The practice of anesthesiology, pathology, physical medicine and radiology are an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine or any other designated field of medicine."

SCHOLARSHIP PROGRAM

To help meet the need for an increasing number of physicians in the future, the House approved the creation of a special study committee which was asked to:

1. Present a scholarship program, its development, administration and the role of the American Medical Association in fulfilling it.

2. Ascertain the maximum to which medical schools could expand their student bodies while maintaining the quality of medical education.

3. Ascertain what universities can support new medical schools with qualified students and sufficient clinical material for teaching—either on a two year or a full four year basis.

4. Investigate the securing of competent medical faculties.

5. Investigate financing of expansion and establishment of medical schools.

6. Investigate financing of medical education as to the most economical methods of obtaining high quality medical training.

7. Develop methods of getting well-qualified students to undertake the study of medicine.

8. Investigate the possibility of relaxing rigid geographic restrictions on the admission of students to medical schools.

The House urged that the special committee be implemented promptly with adequate funds and staff so that it may make an initial report by June, 1960.

RELATIVE VALUE STUDIES

Reaffirming a previous policy statement, the House approved in principle the conducting of relative value studies by each state medical society, rather than a nationwide study or a series of regional studies by the A.M.A. The House also reiterated its authorization for the Committee on Medical Practices to inform each state medical association, through regional or other meetings, of the purpose, scope and objectives of such studies, the steps to be followed in conducting studies, the problems which may be encountered and the manner in which the results can be applied.

The House recognized, however, that some state medical societies are either not interested in relative value studies or are actively opposed to them. It pointed out that some state medical associations fear that the regional conferences of the Committee on Medical Practices will put pressure on them to carry out such studies and that this will result in the adoption of "fixed fees."

Since the regional conferences are educational in nature, the House said, it remains for each state or county medical association to accept or reject the idea of a study in its area.

The House expressed awareness of the fact that this is still a controversial matter. However, it commended the Committee on Medical Practices for its effort to carry out the instructions of the House, and it urged the committee to continue its educational work.

MISCELLANEOUS ACTIONS

In considering 44 resolutions and a large volume of annual, supplementary and special reports, the House also:

Called for investigation of the need, desirability and feasibility of establishing a home for *aged and retired physicians*;

Registered a strong protest to the *Veterans Administration*, urging stricter screening of non-service-connected disability patients admitted to government hospitals;

Reiterated the Association's support of the *Blue Shield* concept and directed the Council on Medical Service to submit at the June, 1960, meeting its recommendations concerning a policy statement on A.M.A. relationship with Blue Shield plans;

Suggested that S.J. Res. 41, a bill which would institute a separate program of *international medical research*, be delayed until an over-all assessment can be made of proposals now before Congress dealing with domestic and international medical research;

Endorsed the program of the Educational Council for *Foreign Medical Graduates* but also urged that

judicious consideration be given to local problems involved in the July 1, 1960, deadline for certification of foreign graduates;

Urged that *medical schools* include in their curricula a course on the social, political and economic aspects of medicine;

Called upon each individual physician to wage "a vigorous, dynamic and uncompromising fight" against the *Forand type of legislation*;

Urged state and local medical societies and individual physicians to implement the A.M.A. program for recruitment of high-grade *medical students*;

At the Tuesday opening session, six state medical societies presented nearly \$250,000 to the American Medical Education Foundation. The checks turned over to Dr. George F. Lull, president of AMEF, were: California, \$156,562; Indiana, \$35,570; New York, \$19,546; Utah, \$10,355; New Jersey, \$10,000, and Arizona, \$9,263.

NEWS

JEFFERY WINS AWARD, YOUNG IS EDITOR

Two members of the staff of the research laboratory of the U. S. Public Health Service in Columbia have received signal honors.

Dr. Geoffrey M. Jeffery has received the Bailey K. Ashford Award given for outstanding work in the field of tropical medicine. The award consists of a medal and a check for \$1,000.

Dr. Martin D. Young, director of the laboratory, has been editor of *The American Journal of Tropical Medicine and Hygiene* for this year.

H. H. Addlestone, M. D., Alfred E. Rawl, Jr., M. D. announce the opening of their office for the practice of Radiology at the corner of Cosgrove Ave. and Arapahoe St., Charleston Heights.

STATE BOARD OF HEALTH

At a regular meeting of the Executive Committee of the State Board of Health was held on October 20, 1959.

It was moved by Dr. King, seconded by Dr. Hanc-
kel, that the recommendation of the Hospital Advisory Council that 1959-1960 Hill-Burton funds in the amount of \$500,000.00 be set aside for the Whitten Village authorities to assist in the construction of an intensive treatment facility for the care of the mentally retarded children of South Carolina, be approved. Passed.

It was moved by Dr. King, seconded by Dr. Camp, that the recommendation of the Hospital Advisory Council that any funds on hand with the Oconee County Treasurer in the Oconee County Hospital Building Fund account on February 15, 1960, not to exceed \$100,000.00, be matched from the 1959-1960

Reserve and further, that if they fail to use all of the mentioned funds any remainder be transferred to general category, be approved. Passed.

It was moved by Dr. King, seconded by Dr. Hanc-
kel, that the recommendation of the Hospital Ad-
visory Council that Nicholson Clinic, Edgefield, South
Carolina, be considered an "existing institution" for
licensing purposes if and when it is re-opened by Dr.
Nicholson, be approved. Passed.

THE COASTAL MEDICAL SOCIETY met De-
cember 10, 1959 at Padgett's Pond near Williams,
S. C. An afternoon bird hunt was scheduled. A
Cocktail Party was given at 6:30 p. m., and the
meeting followed at 7:30 p. m.. Speaker for the
occasion was Dr. Bernard Ferrara of Charleston whose
topic was "Surgical Treatment of Inguinal Herniae
during Childhood."

OFFICERS OF THE CHARLESTON COUNTY MEDICAL SOCIETY FOR 1960

President ----- Dr. J. I. Waring
Vice President ----- Dr. Harold Pettit
Secretary-Treasurer ----- Dr. R. Maxwell Anderson

DR. PRICE ADDRESSES MARLBORO TB GROUP

"More progress has been made in the field of medi-
cine, as well as in other scientific fields, during the
past 30 years than in any comparable period in the
world's history," Dr. Julian P. Price of Florence told
the Marlboro County Tuberculosis Association.

The occasion was the annual dinner meeting of
the TB Association, held this year in the new Marl-
boro Electric Cooperative building.

Introduced by the Rev. Millard H. Osborne of
McColl, president of the T B Association, Dr. Price
recounted some of the advances made in the treat-
ment of many diseases, including tuberculosis.
"Thirty years ago we had no whooping cough vaccine,
no tetanus toxoid, no penicillin, no Salk vaccine, no
sulpha drugs, no cortisone, no antihistamine, and the
death rate from tuberculosis was tragic," he said.

"In the old days it took the pneumonia patient
weeks to recover, if he did recover. Now with peni-
cillin he is out again in less than a week; recovery
from an appendectomy required two or three weeks,
now the patient is walking within a few hours after
leaving the operating room. Drugs for the treatment
of tuberculosis were unheard of."

"These very advances have created problems," Dr.
Price continued. People are complacent until an epi-
demic threatens. They neglect to have their children
immunized against polio and to have themselves and
their children immunized against many contagious and
infectious diseases. An alert and constant educational
and case finding program such as the Tuberculosis
Association provides is needed." He cited as another
grave problem making provision for the older people,
now that the life span has been lengthened.

DR. LEE A. BLAKELY
TO STUDY AT WALTER REED

Having recently transferred from the U. S. Air Force to the Army, Captain Lee A. Blakely, Jr., is now stationed at the Walter Reed Army Medical Center, Maryland, where he has started a three year residency in dermatology.

Capt. Blakely, of Clinton, is a graduate of Presbyterian College and Bowman Gray School of Medicine, and has had one year internship at Walter Reed. He has served in hospitals at Bolling and Andrews AFB for the past three years.

\$450,000 FOR ANDERSON HOSPITAL

Anderson County voters said November 3 by a 2 to 1 margin they were in favor of restoring \$450,000 in funds to the county hospital.

Results are purely for the guidance of the legislative delegation in making additional funds available to restore items deleted in the \$4,400,000 hospital building program.

If the necessary money is on hand by November 13, the county will receive \$400,000 in federal Hill-Burton funds.

The building being constructed next to the Garden Center, on highway 1 in Leesville, will be the new office building of Dr. Bill Speaks. This will be a modern, spacious, and lovely building.

DR. GOODWIN WILL RETIRE

Dr. C. I. Goodwin, Orangeburg County health director since 1946 retired November 17. He was succeeded by Dr. Lucius P. Varn, a Branchville native, and a local physician. Dr. Goodwin plans to return to his home at Helly Hill.

He is a Walterboro native and a graduate of The Medical College of South Carolina in the Class of 1911. He practiced at Walterboro and Meggett before being called into the U. S. Army Medical Corps in 1917. He served in France. In 1919, he returned to Walterboro for a short time before opening offices at Holly Hill, where he practiced for 27 years. In 1946, he joined the Public Health Departments of Calhoun and Orangeburg counties, but for the past several years has worked only in this country. During his service, he has seen modern health centers established at eight points in this county and the County Health Center here.

Dr. Varn was graduated from Newberry College in 1949, and returned to Branchville as high school principal and football coach. Later, he became associated with the U. S. Public Health Service. He afterwards enrolled in the Medical College of South Carolina, being graduated in 1955. After a year of practice at North, he established his office here.

HEART UNIT GRANT

The National Heart Institute has awarded a \$46,150 grant to Dr. Dale Groom of the Medical College of South Carolina for a five-year study of heart sounds.

Dr. Groom, an assistant professor at the Medical College has been making extensive studies of heart sounds to evaluate those not audible in ordinary stethoscope examinations.

GREENE OPENS OFFICES

Dr. Joe E. Greene, a native of Aiken who for the past nine years has been located at Clendenin, West Virginia, where he did general practice of medicine, opened offices in November at 120 Victoria Street in the Professional Building in Greer.

A graduate of the Medical College of Georgia at Augusta where he finished in 1949, Dr. Greene served his internship at Georgia Baptist Hospital in Atlanta and from there moved to West Virginia to practice.

DR. A. W. LOWMAN ELECTED
PRESIDENT SAL SURGEONS

Dr. A. W. Lowman, of Denmark, was elected president at the 57th annual session of the Seaboard Air Line Surgeons, which met at the Francis Marion Hotel in Charleston on October 26, 27 and 28. Six southern states were represented and approximately 280 physicians and their families were present.

The scientific program was presented by the S. C. Medical college. Clinics were held at the Medical College clinic on Tuesday and Wednesday afternoons.

The annual banquet was held in the Francis Marion hotel on Tuesday evening. At this time, the past presidents were presented a gold medal, which were designed with the caduceus encircling the Seaboard emblem.

The following pediatricians have been accepted as Fellows of the American Academy of Pediatrics: Walter Lane Ector, Charleston, S. C.; Charles Alston James, Columbia, S. C.; and Jack Wylan Rhodes, Charleston, S. C.

DR. R. S. SOLOMON

Dr. R. S. Solomon of Moncks Corner received notification from the national headquarters in Chicago that he has been elected a member of the American Society of Anesthesiologists.

This honor is received only by graduate anesthesiologists.

MEDICAL STUDENTS HEAR TALKS

BY DR. C. N. WYATT

Dr. Charles N. Wyatt of Greenville, chairman of the Council of the S. C. State Medical Association addressed the senior medical students of the Medical College of South Carolina recently.

His topic was "Medical Societies and Professional Groups, Their Organization and Importance."

Dr. Wyatt is a past president of the Greenville County Medical Society and the Tri-State Medical Association. He has served as a delegate to the American Medical Association from South Carolina and was one of the founders of the South Carolina chapter of the American Academy of General Practice, serving as its president in 1957.

SEVEN DOCTORS NAMED TO LAURENS HOSPITAL BOARD

The 7-man medical staff at the Laurens County Hospital has won a place on the hospital's board of trustees in a compromise agreement that smoothed out a long-standing dispute.

Six of the seven members of the medical staff had indicated they would curtail their services at the hospital by declining to treat charity patients unless an agreement was reached.

An outright walkout by the doctors also had been rumored.

The doctors had complained that certain administrative and professional operations at the hospital damaged its efficiency and its services to patients.

An agreement was achieved when the Laurens County legislative delegation, somewhat reversing a previous stand, agreed to place a member of the medical staff on the 14-member board.

Dr. Julian Atkinson was recommended by fellow staff members. State Rep. Justin Bridges said today that Dr. Atkinson's appointment to the board has been approved by the legislators.

The compromise also includes a liaison group composed of two medical staff members and two members of the board of trustees. The group will meet prior to each board meeting to air complaints and suggestions about hospital operations.

Dr. M. B. Nickles, chief of the medical staff, said the doctors believe the compromise will result in better services by the hospital.

Services at the hospital were never curtailed during the dispute.

DR YOUNG HONORED

Dr. James R. Young, director of Rose E. Ramer Cancer Clinic of Anderson Memorial Hospital, Anderson, has been elected a director of the American Cancer Society by delegates to the annual meeting of the society in New York City. Long active in cancer control, Dr. Young is a member of the board of directors and the executive committee of the South Carolina Division of the American Cancer Society. He is a past president, past chairman of the board of directors and the executive committee of the division. In 1947, he received the society's annual national division award for distinguished service in cancer control. He is a past president of the South Carolina Medical Association and of the Southeastern Surgical Congress.

MEDICAL SOCIETY OF SOUTH CAROLINA OFFICERS 1960-1961

President ----- Dr. A. J. Buist, Jr.
Vice-President ----- Dr. Ralph R. Coleman
Secretary-Treasurer ----- Dr. F. M. Ball
Librarian ----- Dr. J. I. Waring

DRUG HOUSES CLEARED

Eli Lilly and Company President Eugene N. Beesley has issued the following statement concerning a United States District Court's dismissal of antitrust charges against Lilly and four other polio vaccine producers:

"Of course, all of us at Lilly are pleased by the court's decision that the poliomyelitis vaccine antitrust suit was so completely without basis that it was not even worthy of jury consideration. When the suit was first brought, we labeled it 'complete nonsense' and we never had any doubt as to what the result would be.

"We cannot help being deeply concerned that reputable business firms can be subjected to this kind of baseless attack. The harm done in terms of damage to public reputation by the mere bringing of the suit is incalculable. The waste of company executives' time and the expense of litigating such insupportable charges are deplorable."

In the United States District Court in Trenton, New Jersey, the Justice Department had charged that the five defendant manufacturers had conspired to fix prices of the vaccine. Judge Phillip Forman agreed with the defense attorneys that the Government had not proved its case and dismissed the suit without sending it to the jury.

Dr. Charles H. Epting announces the removal of his office to 2120 Rosewood Drive, Columbia, South Carolina. Practice limited to Orthopedics. By appointment ALpine 2-6267.

The Saul Alexander Foundation has again contributed funds towards the establishment of a new service at the Medical College of South Carolina.

A grant of \$4,500 has been made to the Medical College of South Carolina for establishment of a Laboratory of Psychological Services at the Medical College Hospital. The Grant was included in a total of \$22,970 distributed by the foundation for religious, educational, charitable and benevolent purposes.

A psychological laboratory, through the setting up of statistics and research methodology, is an integral and important part of modern-day research. Such a laboratory at the Medical College would broaden that institution's research projects.

In the future the laboratory would help make it possible to set up an internship program for clinical psychologists, in great demand.

The grant is towards the cost of the first year's operation of the laboratory, which has been estimated to be \$15,000. In its request, the Department of Psychiatry said that the state's Division of Vocational Rehabilitation has indicated interest in the project and willingness to match funds procured elsewhere on a 70-30 basis, which would provide the additional \$10,500.

Dr. L. W. Blackmon has moved his office from 1420 Lady St. to 1516 Gregg St., Columbia.

YORK COUNTY

Dr. James L. Simpson has been elected president of the York County Medical Association for the coming term.

The Rock Hill obstetrician replaces out-going President Dr. William A. Matthews.

Selected to serve with Simpson were Dr. W. H. Williams, Jr., as vice-president and Dr. W. R. Ward, Jr. as secretary. Both men are Rock Hill residents.

In other action at the association's session Monday night, a committee under the direction of Dr. Sam G. Lowe, Jr., was appointed to select a York County Civil Defense medical team.

At present, Dr. Lowe is director of Region E in the South Carolina Civil Defense network.

DR. EVANS RESUMES PRACTICE

Dr. William Evans, Bennettsville, has returned home from Veterans Hospital in Salisbury, North Carolina, where he has been a patient since July.

STAMP ISSUE TO HONOR DR. McDOWELL

A special commemorative stamp honoring Dr. Ephraim McDowell was issued December, 1959, at Danville, Ky., on the 150th anniversary of the first successful ovariectomy, which Dr. McDowell performed on Christmas Day, 1809, according to word received by the Southern Medical Association from Sen. Thruston B. Morton, of Kentucky. Dr. McDowell's portrait is shown.

DR. DORNEY SPEAKS

Dr. Edward R. Dorney, of Emory University Cardiac Clinic was the speaker at the November meeting of the Anderson County Medical Society.

MILLION-DOLLAR RESEARCH CENTER PLANNED BY MEDICAL COLLEGE

Plans have been announced for construction of a million-dollar research building for the Medical College of South Carolina.

Dr. Kenneth M. Lynch, president of the Medical College, told the State Budget and Control Board in that the structure will be financed by bond credits and matching federal funds. He said, however, that funds for staff personnel will be sought from the state later.

Dr. Lynch said the center will "cover almost the entire field of scientific medicine," with cancer and heart disease "heavily emphasized."

Dr. Lynch and other officials of the college appeared before the Board to discuss appropriation requests for the next fiscal year. They asked for state funds of \$1,235,000, an increase of about \$40,000 over the current budget. For the hospital itself, they sought \$1,317,524, a decrease of about \$150,000 from the current state allocation.

Dr. Lynch said an increase in patient income at the Medical College Hospital has offset growing costs of operating such an institution.

He told of the fine cooperation between the Medical



"How Are The Cash Patients Doctor?"

College and Charleston County in providing additional costs for the care of charity patients transferred from Roper Hospital.

He said the county pays \$18 a day for county-supported patients.

He said the medical college is receiving nearly a million dollars from outside sources and that it has 54 national research projects under way for which grants have been obtained.

Gov. Hollings, a member of the Budget and Control Board, termed the proposed research center "a good program."

Dr. Lynch explained that the hospital is "just reaching maturity" and "is in full bloom from top to bottom."

The nationwide Blue Shield Plans and their sponsoring medical societies have registered outstanding progress in implementing the American Medical Association resolution—passed one year ago today—calling for the development of medical care coverage for the aged by voluntary means, John W. Castellucci, executive vice president of the National Association of Blue Shield Plans said recently in Chicago.

"We have just completed a special survey in order to determine the progress made by Blue Shield Plans since the passage of the AMA resolution last December 4 and the results are most encouraging," Castellucci reported.

"Only eight of the 67 Blue Shield Plans located in the United States, with only two per cent of total Blue Shield membership, have no programs for senior citizens in the works at the present time," he noted.

Castellucci said that the remaining 59 Plans either have special aged programs already being offered in their areas, or have programs in various stages of development.

ANNOUNCEMENTS

The 1960 Watts Hospital Medical and Surgical Symposium will be held on Wednesday and Thursday, February 10 and 11.

The VII Congress of the Pan-American Medical Women's Alliance will be held in San Juan, Puerto Rico, June 3-8, 1960. Headquarters will be at the Condado Beach Hotel. Women physicians of North, Middle, and South America are cordially invited to become members and to attend the Congresses which are held every two years alternately in North, Middle, and South America.

Hilla Sheriff, M. D.,
Publicity Chairman

Address:

S. C. State Board of Health

435 Wade Hampton State Office Bldg.

POSTGRADUATE COURSE ON DISEASES OF THE CHEST

The Council on Postgraduate Medical Education of the American College of Chest Physicians will present the 13th Annual Postgraduate Course on Diseases of the Chest at the Sheraton Hotel, Philadelphia, March 14-18, 1960.

We are recruiting a Welfare Medical Director to administer the medical program established in the Connecticut State Welfare Department. The candidate is required to have five years of experience in general practice, preferably in public health. He will be responsible for initiating studies relative to medical costs, including hospital and convalescent care and will maintain liaison contacts with the State Medical Society, State Dental Association, State Health Department, and other medical societies and institutions.

He will supervise an Assistant Medical Director, and Medical Social Work, Dental and Pharmacy Consultants with related staff.

The salary range is \$10,260 to \$13,320.

Bernard Shapiro

Commissioner, State Welfare Department
Hartford 15, Conn.

THE AMERICAN ACADEMY OF GENERAL PRACTICE

The American Academy of General Practice will hold its 12th Annual Scientific Assembly, March 21-24, 1960, in Philadelphia's Convention Hall. More than 4,000 family doctors and 3,000 residents, interns, exhibitors and wives will attend the four-day program highlighting recent progress in medicine and surgery. The Academy has more than 26,000 family doctor members and is the nation's second largest medical association.

American College of Allergists Graduate Instructional Course and Annual Congress, February 28 to March 4, 1960, The Americana Hotel, Bal Harbour, Miami Beach, Florida. For information contact, John D. Gillaspie, M. D., Treasurer, 2049 Broadway, Boulder, Colorado.

MOVIE TAGS MEDICAL ASSISTANT AS "DOCTOR'S PR AMBASSADOR"

The key role played by the physician's medical assistant in creating good public relations is emphasized in a new film now available for showings to medical societies and medical assistants groups.

Entitled "First Contact," the 26-minute dramatic color film shows the mistakes a new office assistant can make unless she is properly trained for her job and points out that medical assistants groups provide opportunities for increasing on-the-job efficiency.

Dr. F. J. L. Blasingame, Executive Vice President of the American Medical Association, who appears in the film, says the medical assistant is a valuable ally in providing better patient care. Says Dr. Blasingame:

"The medical assistant is the doctor's public relations ambassador—often she has first contact with the patient. Her understanding of good doctor-patient relations and her practice of the techniques that create good will are manifold in their value to her physician and the medical profession.

"The professional medical assistant can make it possible for the doctor to concentrate his time on the scientific side of his practice."

In the film Dr. Blasingame comments on the growth of a new national organization, the American Association of Medical Assistants, dedicated to educational improvement and medical profession cooperation. The AMA passed a resolution commending the aims and objectives of the AAMA in December, 1956.

"First Contact" was premiered before 500 members of the American Association of Medical Assistants holding their third national convention in Philadelphia October 16. Prints of the 16 mm film are available to medical societies for showings through AMA's Department of Medical Motion Pictures and Television and to medical assistants groups through the headquarters of the American Association of Medical Assistants in Chicago at 510 N. Dearborn Street.

MEDICAL COLLEGE OF GEORGIA AND

MEDICAL COLLEGE OF GEORGIA FOUNDATION, Inc.

PRESENT

A SHORT COURSE IN OBSTETRICAL COMPLICATIONS IN GENERAL PRACTICE

MARCH 15, 16, 17, 1960

\$50 will be charged for the session. The full fee is

payable at the time of filing application for the course.

This course is acceptable for 18 hours credit, Category 1, American Academy of General Practice.

CLINICAL INVESTIGATIONS IN
HYPERTENSION

The cooperation of physicians is requested in a continuing study of various forms of hypertension being conducted by the Section on Experimental Therapeutics, National Heart Institute, at the Clinical Center, National Institutes of Health, Bethesda, Maryland. Of particular interest are patients having moderate to severe hypertension which is either primary or renal in origin.

Physicians interested in referring such patients for study should write or telephone:

Dr. Louis Gillespie, Jr.
Section on Experimental Therapeutics
National Heart Institute
Bethesda, Maryland
(OLiver 6-4000, Ext. 3175)

PUBLIC HEALTH ASSOCIATION

"Members of the South Carolina Public Health Association should start making their plans to attend next year's 37th annual meeting in Myrtle Beach, but the acquiring of hotel reservations must wait," Miss Elizabeth Davis, president, has announced.

The Ocean Forest Hotel, headquarters for the three-day convention on May 12-14, 1960, has been instructed to accept no reservations until March 1 and then they must be made on an official SCPHA reservation form in order to secure accommodations for the convention. These forms will be mailed out to each association member during the last week of February.

Special room rates at the Ocean Forest Hotel have been secured for association members by the Arrangements Committee, according to Chairman H. C. MacFarlane. The convention rates, *per room*, are:

	<i>Ocean front</i>	<i>Land side</i>
Single occupancy	\$20.00	\$18.00
Two in a room	26.00	24.00
Three in a room	34.00	31.00

The above rates include two meals—
breakfast and dinner.

In order to save convention-goers some inconvenience, Mr. MacFarlane pointed out that each individual will be billed an additional \$1.20 per day by the hotel in order to cover tips for dining room and maid service.

"The hotel's new management has gone all out to cooperate with us in every respect," said Mr. MacFarlane. "They are turning the entire hotel over to us and are furnishing us at no extra cost the dining room, ball room and five meeting rooms which can be used for our section meetings. I feel sure that with the help we are receiving from all quarters, this will be one of the best meetings we have ever had."

THE NEW ORLEANS GRADUATE
MEDICAL ASSEMBLY
16TH ANNUAL CLINICAL TOUR
MARCH 7-10, 1960

HOTEL ROOSEVELT
And Will Be Followed By A
WEST INDIES CRUISE
Puerto Rico — Virgin Islands — Martinique
Barbados — Trinidad — Curacao — Haiti

MONOGRAPH PRIZES
of the
AMERICAN ACADEMY OF ARTS
AND SCIENCES
280 Newton St., Brookline Sta., Boston 46, Mass.
THREE \$1000 PRIZES
To Be Awarded Annually To The Authors Of
Unpublished Monographs — One Each In The
Fields Of The
1. Humanities
2. Social Sciences
3. Physical and Biological Sciences

The South Carolina Medical Association urges you to

FIGHT FOR AND

Send a handwritten letter to your congressmen and any others who may have
a voice or a vote.

PHARMACEUTICAL MANUFACTURERS
ASSOCIATION
STATEMENT OF PRINCIPLES OF ETHICAL
DRUG PROMOTION

(Passed by the P.M.A. Board of Directors, May 24,
1958)

WE, members of the Pharmaceutical Manufacturers Association, recognizing our responsibilities and obligations to promote the public welfare and to maintain honorable, fair, and friendly relations with the medical profession, with associated sciences, and with the public, do pledge ourselves to the following statement of principles:

1. Prompt, complete, conservative and accurate information concerning therapeutic agents shall be made available to the medical profession.
2. Any statement involved in product promotional communications must be supported by adequate and acceptable scientific evidence. Claims must not be stronger than such evidence warrants. Every effort must be made to avoid ambiguity and implied endorsements. Whenever market, statistical or background information or references to unpublished literature or observations are used in promotional literature, the source must be available to the physician upon request.
3. Quotations from the medical literature or from the personal communications of clinical investigators in promotional communications must not change or distort the true meaning of the author.
4. If it is necessary to include comparisons of drugs in promotional communications, such comparisons must be used only when they are constructive to the physician and made on a sound professional and factual basis. Trademarks are private property that can be used legally only by or with the consent of owners of trademarks.
5. The release to the lay public of information on the clinical use of a new drug or of a new use of an established drug prior to adequate clinical acceptance and presentation to the medical profession is not in the best interests of the medical profession or the layman.
6. All medical claims and assertions contained in promotional communications should have medical review prior to their release.
7. Any violation of these principles brought to the attention of the President of the Pharmaceutical Manufacturers Association shall be referred by him to the Board of Directors.

DEATHS

DR. C. H. WORKMAN

Dr. Claude Henry Workman, 71, a practicing physician for 45 years, died unexpectedly on November 15 at his home in McCormick.

He was born at Chappells, August 14, 1888 and was a graduate of Central Plains College, Texas, and

was graduated from Emory University Medical College in 1914. He began practice in Chappells. He later moved to Troy where he lived for ten years. In 1925 he moved to McCormick where he maintained a modern clinic. Dr. Workman was local surgeon of the C. & W. C. railroad, McCormick County physician, and was formerly the doctor for the John de la Howe School. He was medical advisor for the local Selective Service Board.

The soft spoken, genial spirited doctor was much beloved as a family physician, citizen, and personality. In August 1958 he was honored at a "Workman Day Celebration" by the citizens of McCormick and surrounding areas, for the faithful service he had rendered.

DR. JAMES W. DAVIS

Dr. James W. Davis, Clinton's most beloved citizen, and a practicing physician there since 1896, died November 4 at Ponce de Leon Infirmary, Atlanta, where he had gone for cataract operations on his eyes.

It was understood that Dr. Davis died on the operating table.

Dr. Davis was in his 90th year. He was never married, and was the last surviving child of his parents.

He was born near Clinton, April 25, 1870 and was graduated from Presbyterian College (then Clinton College) in 1890, and taught school one year at Moffattsville, near Iva in Anderson County. He entered the Medical College of South Carolina in Charleston, graduating in 1895. He served one year as an intern at Charleston City Hospital (now Roper Hospital). In 1896 Dr. Davis returned to Clinton where he continued his practice since, though in late years in a somewhat limited way.

Dr. Davis was named "Citizen of the Year" by the South Carolina Moose Association in 1957 and the award was a highlight of a three-day convention. Many other honors were bestowed upon him.

CLINICAL CENTER STUDY OF CHONDROSARCOMA AND THYROID CANCER

The cooperation of physicians in nearby areas is requested in studies of chondrosarcoma and of thyroid cancer being conducted by the Radiation Branch of the National Cancer Institute in the Clinical Center of the National Institutes of Health, Bethesda, Maryland. The primary purpose of the study is to determine the possible effects of large doses of radioactive Sulfur-35 on patients with inoperable but accessible (for biopsy) chondrosarcoma.

Write to:

Charles G. Zubrod, M. D.
Clinical Director
National Cancer Institute
Bethesda 14, Maryland
(OLiver 6-4000, Ext. 4346)

BOOK REVIEWS

CLINICAL AUSCULTATION OF THE HEART.

Samuel A. Levine, M. D., Sc.D. (Hon.), F.A.C.P., Clinical Professor of Medicine, Emeritus Harvard Medical School, and W. Proctor Harvey, M. D., Associate Professor of Medicine, Georgetown University School of Medicine. W. B. Saunders Company, Philadelphia 1959. 657 pages. Price \$11.00.

This second edition of the new well known textbook on auscultation is, as its title implies, written entirely from the clinical standpoint by two clinicians who are pre-eminent in the field of auscultation. In pooling their experience they have produced a practical and comprehensive treatise which most physicians who use a stethoscope will find well worth the reading.

The book is divided into four parts: Heart Sounds, Cardiac Irregularities, Cardiac Murmurs, and Miscellaneous Auscultatory Findings. References and bibliography are omitted. Phonocardiographic illustrations are abundant and, for the most part, display well the features discussed in the text. One might like to see a few illustrations made with more advanced methods of recording than the conventional phonocardiograph which has incorporated almost none of the electronic advances of the last two decades but doubtless many years were required for the accumulation of such a wealth of tracings.

The authors point out that, despite the fact that the stethoscope has been part of the doctor's kit for one hundred and thirty years, "it is not being put to its best use by the medical profession," and that in an age of constantly increasing costs of medical care physicians should "derive all possible help from such an inexpensive and expedient tool as the stethoscope." Levine and Harvey's "Clinical Auscultation of the Heart" is an excellent guide for getting the most out of the few minutes required for careful auscultatory examination.

Dale Groom, M. D.

Science and Psychoanalysis, Volume II, *INDIVIDUAL AND FAMILIAL DYNAMICS*. Jules H. Masserman, M. D., Editor. 214 pages—Grune & Stratton, Inc., New York 1959.

This book is the second volume of the scientific meetings of the Academy of Psychoanalysis, 1958. In this volume the various authors continue to develop a clearer terminology and understanding of basic psychiatric syndromes. As in the case of the first volume, this work continues to place psychoanalysis and intensive psychotherapy in a setting of medical understanding that removes it from the realm of occultism. In this respect, this book is extremely valuable and helpful, not only to the psychoanalysts, psychotherapists, and psychiatrists, but to those in the medical profession who want to be assured that the roots of psychotherapy lie in scientific strata, and

not in some miasmic clouds of theoreticism. The two main sections of the book deal with two basic psychiatric syndromes, one, masochism, and two, a similar full discussion on the psychological forces in intra-family relationships. The basic, underlying emotional pattern of masochism is discussed in a very fruitful way, much like the psychological forces in *e. g.* dependency. Earlier theories represent masochism *per se* as a need for personal punishment, suffering, or expiation, in the same way that dependency used to be represented as a failure to take one's own personal responsibility in various life situations. Masochism is clinically demonstrated in many forms other than the commonly conceived types, such as the sexual masochist, or the moral masochist. The patients who persistently do not seem to want to get well, the obsessively hypochondriacal patients, the "medical shoppers", those with intense somatization of their emotional problems, are all included in this expanding practical concept of masochism. Therapeutic efforts can now be freed to relate masochism to deeply personal difficulties and failures (Ego weakness, or self-contempt) experienced in such basic personality traits as feelings of unworthiness or fear of any form of spontaneous self-expression.

The second section of the book deals with various forms of experimental and clinical psychotherapy with various members of a family, one of whose members is the main patient. An interesting article on the principle of the reinforcing, intertwining and "feedback" factors in emotional disease, seen particularly in family relationships, is very enlightening. It emphasizes the tremendous importance of not only knowing clearly about other significant family members, but particularly how unhealthy emotional forces, originally minor, grow into major disease proportions through constant distortion, coloring and misinterpretation.

This book is highly recommended for its clarity, simplicity, and its depth of usefulness.

Norton L. Williams, M. D.

A WAY OF LIFE AND OTHER SELECTED WRITINGS OF SIR WILLIAM OSLER, Dover Publications, Inc., New York, New York. Price \$1.50.

This review might be simplified by quotations from the Editor's Note:

"These essays have been chosen by a Committee, with remarkable accord, to give the medical student a taste of Osler. He will meet here not Osler the pathologist, not Osler the clinical professor, but Osler the essayist and historian. Yet in Osler these interests were not truant from true medicine itself, for he believed that history and the knowledge of men were as much part of medicine as the latest technical devices and the knowledge of science.

"When Osler first wrote his textbook, in the sphere of treatment the age of reason had hardly started, though the age of faith had passed. The advances of these fifty years have eaten largely into the idea of

man healing man, and now committees cure diseases. Yet the ordinary man with his ordinary medical ills seeks first a fellow human for advice and comfort as well as drugs. And so Osler the physician telling of his interests in the history of medicine and medical men, of his ideas about the doctor's vocation, and of his love of books has still a part to play in the training of doctors for the practice of the art."

And again, a quotation from the Introduction:

"The passing of his centenary has seemed to be a fitting time at which to remind the English-speaking world of the significance of the life and writings of this great man by publishing a new selection of his essays. It is indeed to the English-speaking world, and not only to its doctors, that his message is addressed, for Osler was as great a humanist as he was a doctor. The sweep of his mind and interests embraced every phase of human activity, and his example of how to live can inspire the lives of many others besides the younger members of his own profession."

When only recently this reviewer became aware of the fact that the present generation of medical students, or at least many of them, know little or nothing about Osler, and probably nothing or less about his writings, he wondered whether there was any way in which the writings could be brought to their attention, and indeed of many of the present day doctors. This book, handy, inexpensive, and well printed, might seem to be the answer to the need and might do much to save from neglect some of the remarkably fine writings for which Osler was well known. It is a book which any student can afford and one which would make a nice inexpensive present from some of his preceptors. Let us thank the publishers for a fine contribution.

JW

Progress in Psychotherapy, Volume IV *SOCIAL PSYCHOTHERAPY*. Jules H. Masserman, M. D. and J. L. Moreno, M. D., Editors 347 pages. Grune & Stratton, New York 1959. Price \$8.75.

This book is another example of the continuing, successful attempts to provide the medical profession at-large with the source materials of psychiatry. All factors—individual, social, cultural, economic et al, with which all physicians, not only psychiatrists, must deal in the problems of mental and emotional health, are laid out in clear perspective. The only criticism for the book, perhaps, is the broad extent of coverage, not its content. However, I would consider this a minor defect, well-compensated by the fact that the articles are not too long and that one or two points of each article provides its substance. For example, in the article on the "Semantics of Psychotherapy", psychotherapy as a medical discipline, not one primarily for psychologist or minister, is assured by its primary clinical use of unconscious forces and factors. In the article on "Science, Psychiatry, Religion," the position of psychotherapy is thoroughly exorcised from the stigma of self-sufficient humanism.

The mystical-like experiences that take place in the individual during psychotherapy are related much more to an expanding experience, than to a mere reducing of one's life to a few causal determining facts. There are other interesting articles on the changing patterns in mental and emotional disease syndromes, as the result of changing cultural patterns, provide material for a few articles. One particularly good article covers the problem of certain types of therapy for certain types of patients according to social class structure. Here the study revealed that there was a definite association between class position and being a psychiatric patient, and that the lower the class the greater the proportion of psychiatric patients. In other words, higher class or economic level does not necessarily provide for more adequate use of psychiatric facilities. This is contrary to the popular belief that economic factors are responsible for the difficulty in getting psychiatric help. There are other current interests described adequately, such as use of drugs, extra-mural factors, such as the "Open-Door" policy in mental hospital, psychiatric family case work, rehabilitation procedures, and pastoral workshops.

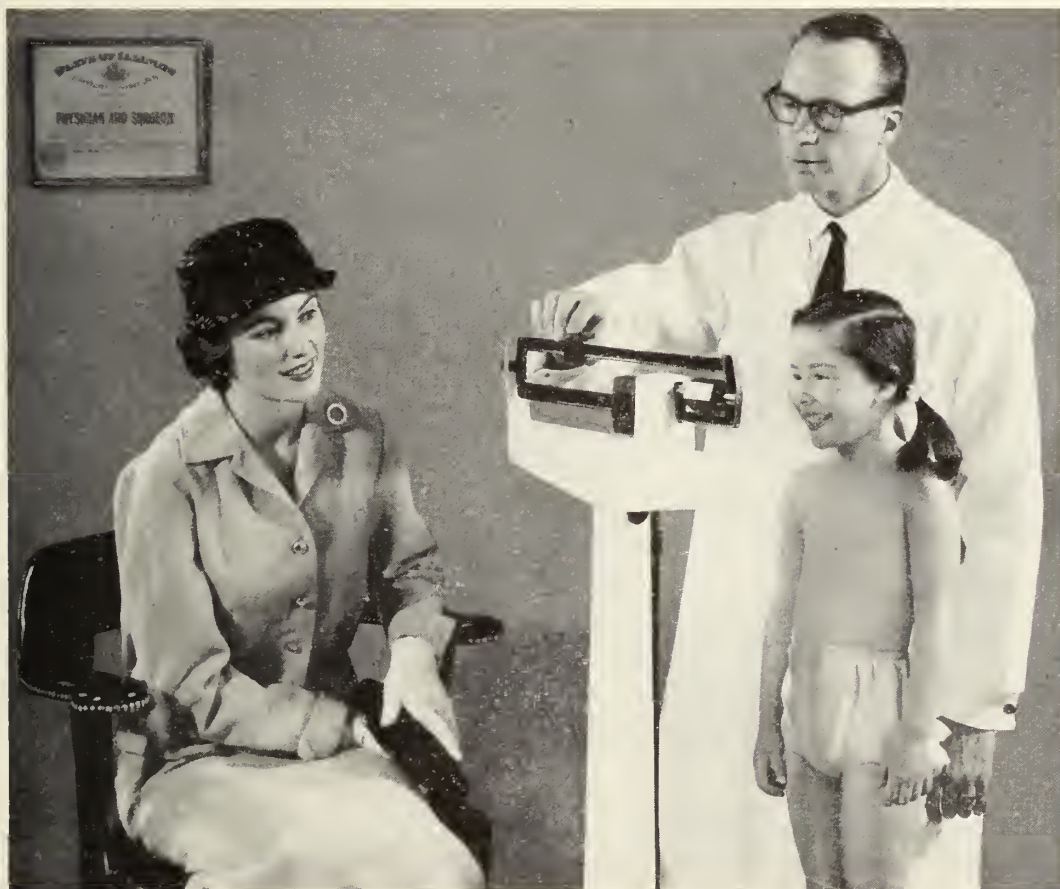
Finally, there is a global panorama of psychiatry as practiced in Middle and Far East. All in all, it is quite a fascinating survey, and one can read and learn from this book, like a tourist, without having to learn a whole new language, nor be subjected to foreign isms.

Norton L. Williams, M. D.

Ciba Foundation Symposium on *CARCINOGENESIS. MECHANISMS OF ACTION*. G. E. W. Wolstenholme and Maeve O'Connor. Little, Brown and Company, Boston. xii + 336 p. 48 illustrations. \$9.50.

The names of the 23 participants in the Ciba Symposium on carcinogenesis held June 24-26, 1958 read like a list of who's who in the field of the cause of malignant growths. Professor A. Haddow presided with a light but masterful hand, and he presented the role of metals and metal chelating in carcinogenesis. J. Furth presented mechanisms of virus action, I. Berenblum discussed skin tumors, O. Muhlbock and L. M. Bost hormones as carcinogens, I. and M. Bishowsky alloxan-diabetic rats, H. Druckrey the pharmacology of carcinogenesis, and H. N. Green the immunological aspects of cancer. G. M. Bonser, J. W. Jull, and E. Boyland discussed the action of amines in the origin of bladder cancer, while H. S. Kaplan, A. C. Upton, and R. Latarjet pictured the latest findings in the induction of lymphomas and leukemia.

The discussions which followed the formal presentations of the papers brought into clear focus the fact that while there are many hypotheses of carcinogenesis, which are little more than the re-statements of the facts of experimental observation, that there is at present no theory of carcinogenesis. The fluctuating nature of current ideas offers an unparallel challenge to pursue both the empirical and the theoretical ap-



Underweight Children Gain and Retain Weight with Nilevar[®]

One of the most convincing evidences of the anabolic activity of Nilevar, brand of norethandrolone, has been its ability to improve appetite and increase weight in poorly nourished, underweight children.

A highly important feature of the weight gain thus produced is that it is not ordinarily manifested by deposition of fat but as muscle tissue resulting from the protein anabolism induced by Nilevar.

Anorexia and "Weight Lag" Study—Brown, Libo and Nussbaum have reported* consistent and definite increases in rate of weight gain in eighty-six patients, ranging in age from 7 weeks to 15½ years. This beneficial action of Nilevar was observed in the patients with organic and traumatic disorders as well as those whose only complaints were poor appetite and/or persistent failure to gain weight.

In this study, the weight gained was not lost

after discontinuance of Nilevar therapy although many patients did not continue the sharp gains effected by the drug.

The authors are of the opinion that Nilevar is a highly useful anabolic agent for influencing weight gain in underweight children.

When Nilevar is administered to children a dose of 0.25 mg. per pound of body weight is recommended and continuous dosage for more than three months is not recommended.

Nilevar is supplied as tablets of 10 mg., drops of 0.25 mg. per drop and ampuls of 25 mg. in 1 cc. of sesame oil. Further dosage information in Searle Reference Manual No. 4.

G. D. Searle & Co., Chicago 80, Illinois.
Research in the Service of Medicine.

*Brown, S. S.; Libo, H. W., and Nussbaum, A. H.: Norethandrolone in the Successful Management of Anorexia and "Weight Lag" in Children, Scientific Exhibit presented at the Annual Meeting of the American Academy of Pediatrics, Chicago, Oct. 20-23, 1958.

proach to the baffling problems on the mechanisms of carcinogenesis.

John R. Sampey

MEDICINE, COACHING, AND . . .

The high school athlete

Confluence of the medical and coaching roles in the treatment and reduction of athletic injuries was the subject of a symposium on "The High School Athlete" sponsored May 19 by the Florence School District One Board of Trustees and Coaching Staff.

Six medical specialists from the Florence area described to the coaches attending the meeting from Darlington, Marion, Horry, Williamsburg, Dillon, Clarendon and Florence counties the steps to be taken in the care and treatment of injured high school athletes to prevent their injuries from becoming major or permanent. Treatment of knee, ankle and head injuries; care of eyes and skin; the team physician and his importance to the coach and team; and coaching and conditioning to avoid injuries were discussed.

Head football coach Warren Giese of the University of South Carolina outlined for the high school coaches a physical conditioning program similar to the one used by his freshmen. It is designed to strengthen the athlete for his protection through stretching and weight-training (not to be confused with weight-lifting) exercises.

Training rules should be few, valid, and purposeful and not restrict the normal activity of the athlete. Parents and the public should be informed about training regulations in order that they might help the player abide by them, Giese said.

A coach should not work his team too hard in early-season practice. However, there should be no concern about overwork unless all the players' weights start dropping uniformly. Drudgery in practice is unfavorable for team morale and can be eliminated by variation of drills. Mid-season work should go full speed because an athlete is less inclined to be injured in full-speed drills. The majority of scrimmage injuries result from piling on, Giese pointed out.

Injuries to knee ligaments, the ankles, and the head and their care and treatment by the coaching staff were discussed respectively by Dr. George Dawson and Dr. Burr Piggott, orthopedic surgeons, and Dr. N. D. Ellis, surgeon.

Severity of the damage to knee ligaments can be determined by comparison of the injured limb to the other and noting the contrasting appearance and mobility. Application of cold and compression should be made immediately to knee injuries with heat treatment being delayed for at least twenty-four hours following the impairment.

In an injury where the ankle is driven to one side, the first twenty minutes before swelling and hemorrhaging begin are the most important. If there is a fracture, the deformity should be reduced as quickly as possible and cold and compression applied. Heat should never be used in ankle injuries until at least forty-eight hours have elapsed. Novocain injections for pain relief during physical activity should be strictly avoided. Rest and elevation are recommended until there is no limp or pain, and the injured ankle should be strapped for all participation in physical activity for a year following recuperation. About half of all ankle damage could be prevented by strapping.

An athlete should never be allowed to continue participation after even momentary unconsciousness resulting from a head injury without at least a twenty-four hour observation period by a physician. All symptoms following a head injury, such as twitching and vomiting, should be noted by the coach and reported to the doctor in charge. Most athletic head injuries are concussion, or temporary loss of nerve impulses, and are not immediately fatal.

Eye and skin care methods for high school athletes were outlined for the assembled coaches by Dr. L. D. Lide, ophthalmologist, and Dr. George Smith, dermatologist.

The use of glasses while participating in athletics should be restricted to lens which are plastic or shatterproof. Contact lens are excellent but should be worn at all times and not during athletic competition only.

Skin care consists primarily of cleanliness and dryness with clean clothes and adequate drying after a shower. An athlete with severe acne or other bacteriological infections should never be allowed to participate in sports which might endanger him with permanent scarring. Face acne is not as dangerous as body spots which could possibly be rubbed by equipment. Dryness and a good powder are the best treatment for fungus growth.

The importance of a cooperative system between coaches and team physicians was discussed by Dr. W. M. Hart, Florence High School team physician. The duty of the team physician is to treat all injuries and prevent minor ones from assuming major proportion through neglect. The coach and physician must work together at all times in the period of gradual rehabilitation, with the coach reporting all developments to the physician. This spirit of cooperative treatment and observation reduces the calculated risk of injury and offers a better and safer sports program for the participants and the public.

Officials at Florence have expressed hope that this type of meeting can be carried on there as an annual affair.

From South Carolina Schools

The Journal

of the

South Carolina Medical Association

VOLUME LVI

February, 1960

NUMBER 2

THE EMOTIONAL RESPONSE TO TUMORS OF THE BREAST

CHARLES WATKINS, M. D.
NEW ORLEANS, LA.

Case reports illustrating the effect of emotions on the course of medical illness appeared in the ancient literature. One of the earliest reported cases involves Democedes, who is described as being one of the most successful physicians of antiquity. Herodotus, the Greek Historian, tells of Atossa, the wife of the Emperor Darius, who developed an abscess of the breast which she concealed because of shame. It was only after she became dangerously ill that she sought treatment for it. Fortunately, the outcome in this case was successful, but in too many instances such shame about one's body leads to delays which make for irreversibility of the pathological process.

We have been actively engaged in psychiatric evaluation of women with masses in their breast for two years at LSU. During the first year, our study was limited to patients who had been admitted to the hospital for biopsy or for radical surgery. During the second year of study, we moved into the out-patient clinic in an attempt to see the patients on their initial visit with this complaint. It is our impression that with in-patients, the hospital atmosphere rapidly influences the psychological reaction of the patient.

Our interest in the problems of cancer and its psychological aspect was initially motivated by the desire to study individuals who were undergoing severe psychological stress. This disease offered an excellent opportunity for such a study of stress, as it commonly tends to be chronic, frequently irreversible, often pain-

ful, and surrounded by many superstitions. In addition to this interest which was purely research, we had become actively engaged in a teaching program in our medical school in which we were responsible for the discussion of the psychological aspects of the cancer problem. This turned our interest from a purely investigative one to the area of practical application in the clinical setting. Finally, we were asked to participate in planning for a symposium on breast cancer to be held in our city, and it was this factor which determined our selection of the breast as the area of initial study. Although the selection of this site was purely accidental, we feel that it is an extremely fortunate choice. The breast is an area of the body, readily accessible to observation, and one about which most women are somewhat knowledgeable. The mass usually develops in a previously asymptomatic area. Because if this, there is relatively little opportunity for the patient to mistake the signs of expanding mass in the breast for those referable to a previous complaint in the same area. This is frequently not the case in lesions of the gastrointestinal tract or of the genitourinary tract.

The material upon which I am going to base this discussion involves only out-patients of our particular study, and information obtained from other workers in this field.

Because this study was done on a relatively small number of patients, we do not feel the material that we have to offer is of statistical significance in the usual sense of the word, but rather the patients must be looked upon as individuals responding in their own unique

manner, presenting types of response that need to be investigated further. We have detailed information including psychological examination and social service investigation on only twelve patients. These individuals are in various age groups. They come from both the white and negro Southern population. They were all patients at a charity hospital and none of them had college educations.

In the patients that we saw, it was striking that there was a much greater willingness to express concern openly over the possibility of cancer in those individuals who came for care very soon after having discovered a lump in the breast. This fear of cancer in these individuals was always countered by the comment that they knew that if you "got it early," things would work out all right. We doubt seriously that the patients were actually this certain of an optimistic outcome, but at least this is the attitude that they expressed and they did seek early care.

In our group, those individuals who delayed seeking treatment for an unreasonable period of time were individuals in an unsettled family situation. This has been true of both the young patients and the old patients. In our psychiatric evaluation of these patients, it rapidly became apparent to us that all of them were severely depressed. All expressed the feeling of hopelessness and of despondency, and in every instance this feeling of hopelessness was projected into a real family situation. I am not now talking of projection and distortion in a psychotic manner, for the situations were as described by the patient when we investigated them through social service. In the examination we made of these patients, they would occasionally fail to speak about their breasts at all, spending all of their time talking about their other troubles. For example, one of our patients, a woman in her sixties, spent practically all of her time talking about an alcoholic son-in-law who was not supporting the patient's daughter, and who was very hostile to the patient. This daughter was described by the patient as being on the verge of a nervous breakdown from worry, brought on to some extent at least, by the discord between the patient and the daughter's husband. This was the situation to which the

patient would return if she were successfully treated for her disability. We can only speculate as to whether or not the patient delayed, consciously or unconsciously, as a method of effecting an escape from this relatively unpleasant situation.

Another patient, perhaps an even more interesting one, a woman in her mid-forties was hospitalized with an inoperable malignant growth nine months after she had accidentally discharged a shotgun through her abdomen. The growth was discovered only by accident when she went to her local physician because of an acute viral infection. This woman had lost her husband when she was quite young, and was left with two small children to raise. She raised the children herself, stating that while her children were young she would not consider marriage, for she would not risk subjecting her children to a stepfather who might be less kind and tolerant to them than she desired. Shortly after the marriage of her son, the daughter being already married, she began actively to socialize, and soon married. Within a year the son had developed an acute schizophrenic reaction, his wife had deserted him and their child, and the son returned to the patient bringing with him the grandchild. The patient stated that she was very upset about this, as she had to do something that she said that she would never do, and she saw no solution to the problem. It is, I think, not unlikely that the accidental shooting was strongly motivated by the desire to escape from an intolerable situation, and I suspect that the neglect or lack of awareness of the lesion in an intelligent and observing woman might have been due to the same reason.

Another finding that was consistent throughout our series was that women past the child bearing age openly expressed more concern about the possibility of loss of breast than did the women who were still in the child bearing age. These elderly women could not give a very clear explanation of why they were so concerned about the loss, whereas, the younger women clearly expressed the regret over such a possibility, but stated that if loss of breast was necessary for them to remain alive, they would willingly give it up.

One finding which was incidental, and I hope not very common, is that a physician, closely associated with a patient, appears to be more likely to deny the possibility that a lesion is malignant, and therefore needs definitive investigation, than is a physician who is able to view the patient more impersonally.

With these generalizations from our own studies, I would like to turn to the more theo-

retical aspect of the problem and discuss some of the psychological phenomena that are present with this type of illness, how these phenomena can be recognized, and how, by this recognition, the physician can be of more service to the patient.

A number of workers have attempted to formulate some principles or rules of behavior that appears to be applicable to stress in general.

In evaluation of an individual's response to stress, three factors must be considered: First, the general reaction to stress. Second, the personal reaction to stress. Third, the nature of the stress.

The general reaction to stress might be considered to be the sequence of responses that are likely to occur in an individual who is subjected to stress of varying degrees of severity of whatever nature. For ease of discussion we might assume that the stress is considered by the patient to be of a catastrophic nature. The general reaction then would be considered to be the course of events from the time of the recognition of the stress to a point where there is a resolution of the stress either by mastery or by destruction. Illness may be looked upon as such a nonspecific stress to which an individual is subjected.

It might be noted that in the particular situation that we are describing, the patient may use these mechanisms at the time of discovery of a mass in the breast, may work through them at various levels, can then repeat the sequence at the time of the physical examination and the discussion of the problem by the physician, and finally again at or after surgery, and during the course of the termination of the illness. Each of these phases of the illness, the discovery by the patient, the examination and explanation by the physician, and the treatment procedure are all stresses and must all be handled by one means or another.

Table I gives a schematic representation of one proposed sequence in such a situation. Phase 1, the state of disorganization comes at the point of recognition of a stress, and may last for varying periods of time. Some individuals subjected to severe stress appear to lose all ability to organize their thoughts and

GENERAL REACTION TO STRESS

Phase One	The Period of Disorganization A. Chaotic Reaction B. Depersonalization
Phase Two	The Period of Assimilation A. Projection B. Denial
Phase Three	The Period of Mastery A. Grief B. Resolution 1. Childish dependency on Physician 2. Omnipotent identification 3. Adult cooperation and acceptance

(Modified from Shonds)

behavior, and behave in a chaotic manner. This is seen, for example, in the individual who brings something of a relatively trivial value out of a burning house, or who actually might rush back into a house that is about to collapse for an object of trivial value. A patient, who has been told of a serious illness, may get up and leave the office, and later deny that she was told of her illness by the physician. She was completely unable to assimilate the information into her awareness, and was therefore unable to utilize medical assistance. This is, as a rule, fairly transient. The individual then goes into the phase that has been described as depersonalization where they are aware of what has taken place, but they seem to be at the moment unable to realize that it is happening to them. The patient later describes having gone through a period when she was well aware of what the doctor said but it seemed that the physician had been talking about someone else.

It is obvious, of course, that in either instance, the patient is temporarily overwhelmed by the impact of the information, and is unable to do anything with it and therefore finds difficulty in accepting the need that something must be done.

The next phase, that of assimilation, occurs at the point where the patient is able to recognize the implication of the situation but attempts to handle the anxiety by discrediting the informant. This can be done by projection, in which case, the responsibility for the situation is placed upon outside sources. In the

medical setting, it is commonly seen in the complaint that the illness is the doctor's fault, or the nurse's, or what have you. This, of course, can lead to unpleasant consequences and should always be recognized as one of the complications likely to occur in any serious illness. It is usually handled fairly easily without damage either to the physician or to the patient. Denial, on the other hand, can be much more serious because it can lead the patient to refuse medical care, stating that the information that she has received is inaccurate and that there is actually nothing wrong with her. This is quite different from the lack of awareness exhibited in the stage of disorganization, because in this instance, the patient is actually aware of what is being told her, is aware of the implication of the situation, but by the magic method of saying that it isn't so, is attempting to handle the problem. Phase three, the phase of mastery is initiated by the recognition of the implication of stress, and by the natural grief that it might be associated with any loss or deprivation that is likely to take place. This is followed by a stage of solution where the patient may solve her problem by (1) becoming a relatively helpless dependent individual, (2) by developing an omnipotent identification with the physician, or (3) ideally by accepting a realistic evaluation of the situation, and development of behavior commensurate with the reality.

This brief outline of the general reaction to stress shows how an individual can go through various phases of psychological responsiveness during an illness, or during the period of medical examination. It is clear that there are many modifications of this procedure based upon the individual capability and potential of the patient. The individual, subjected to medical illness, is likely to respond in a pattern consistent with her usual reaction to stress. The discovery of a mass in the breast, or the information that surgery is necessary, or finally, the recognition that surgery was unsuccessful is a stress situation to which the individual can respond only with her general pattern of behavior. This can be illustrated in the next table where a number of type re-

actions are listed that might be expected to occur in women with breast mass.

SPECIFIC REACTIONS TO STRESS

1. Dependency
2. Anxiety
3. Depression
4. Compulsive Reaction
5. Paranoid Reaction
6. Schizoid Reaction

(After Sutherland)

It is evident from comparison of, or with, Table I that there are some reactions that are common to both. There is a likelihood of a general depressive reaction to the recognition of serious illness, and in addition, certain individuals are likely to behave in a consistently depressed manner with a greater degree of depression that is common in the general population. These responses need little or no amplification, because they are the emotional reactions that are seen in various types of psychiatric patients, or in individuals with mild personality patterns of this type. It is important that they be recognized, however, because the method of handling the individual should be influenced by the general personality pattern. For instance, the anxious individual is likely to require considerably more reassurance than another individual not chronically anxious. The individual with anxiety is also likely to react more readily and rapidly to the development of symptoms, and will seek help earlier, and may therefore have a somewhat better prognosis than will some of the other types. The depressive individual, with a feeling of general hopelessness, or who feels unworthy, might, as a reaction to this attitude, fail to ask for sufficient care, and could then come in to the physician in a terminal state as the result of delay brought on by this depressive attitude. We have already discussed how the paranoid, or projective mechanisms, may cause difficulty in relation

to the general reaction. The schizoid reaction can result in a general denial or failure to handle the situation, and it also has been described to some extent in the general reaction. The compulsive person will follow orders well, and can, in many instances, gain immeasurable help if this is recognized and the patient is offered certain rituals to carry out. The dependent individual we do not need to describe; he is well recognized and will insist himself that you care for him.

We have now talked about the general reaction, and the specific reaction. It is now necessary for us to recognize that in addition to the general personality characteristics, the reaction of an individual is going to be determined, to some extent, by the specific nature of the stress.

Stress of any sort has its specific consequence to the individual. The stress of illness has associated with it the possibility of loss of function, of pain, and loss of body integrity to death. The byproducts of such loss of function might include the loss of independence, the loss of status activity, and the reduction in social desirability.

Recovery from illness is not always an uncomplicated return to the previous state of well-being; not infrequently, recovery is secured at the expense of a loss of body part, with an associated reduction in body function, and reduction in the concept of desirability. This loss varies with the level of awareness of the body part, and with the specific values associated with it.

We know that the breast, by its very nature, has a high emotional charge. The girl, from the time of puberty, well within the limits of conscious memory, is highly motivated to place much emphasis on the breast. The developing breast is the first public evidence of beginning womanhood. No matter whether cherished or bitterly rejected, feeling associated with such an organ is strong. This importance is rapidly reinforced by the tentative explorations and approaches of the adolescent boy friends, making the breast not only a harbinger of womanhood, but an integral part of adult sexuality. Depending upon the overall attitude toward sex at this point and later, this interest might develop as a healthy com-

ponent of maturity, or might be repressed either with denial or reaction formation associated with conscious and unconscious guilt.

During adulthood, there is further reinforcement of the feelings associated with the breast, whether the woman be single or married, reproductive or barren, and finally after the menopause the breast remains, long after the cessation of the menses, as a reminder and a symbol of feminine sexuality.

It is little wonder, with this heritage of psychological sensitization, that a lesion occurring in the breast is likely to cause much more reaction than would a similar disturbance in most other parts of the body.

The emotional reaction to the healthy breast can range from an almost complete denial of its existence, through reaction formation which creates an attitude of disgust and rejection as if it were dirty, through a healthy respect and regard for a decorative and utilitarian part of the anatomy, to a narcissistic preoccupation and over-evaluation.

These specific attitudes toward the breast will influence the general reaction of the patient to discovery of a breast mass. The individual, who devaluates, may either fail to care for herself adequately, or she may, because of her depreciatory attitude, come rapidly to the physician with the expressed joy of being able to get rid of this useless appendage that has been nothing but a bother and a burden anyway. Beware of such acceptance, it usually hides severe depression, frequently associated with suicidal guilt. At the other extreme is the narcissistic individual who demands immediate repair and restoration to previous states of function. The loss of self esteem, secondary to the narcissistic insults to the body, may result in refusal to accept surgery, or in depression and suicide after surgery, if it is not recognized and handled.

We must not fail to recognize that many women do not live in isolation, but have husbands who are important in their lives. The attitudes of the husband toward the wife is important, not only before surgery when it may actually delay surgery as it did in one of our cases, or afterwards when it may ad-

versely influence the postoperative course if not taken into account.

The particular patient, to whom I have reference, came to the hospital with inoperable metastasis. She had discovered a mass months earlier, surgery was recommended but it has been delayed while her husband underwent an elective herniorrhaphy and prolonged convalescence during which time the patient nursed him. She was justifiably depressed over this.

We must also recognize the role that the physician plays in such situations. He can, by his actions, at times influence the patient to a favorable outcome, at other times an unfavorable one.

I am sorry that I have not been able to present data that would make the reaction of the woman with a breast mass easy to predict and simple to handle. It is beyond my capability to do so. I have attempted to present a few conclusions drawn from a limited number of cases, and then to discuss some general rules of behavior which influence the individual patient. I can only say that it is most im-

portant for the physician to recognize that emotions influence the patient's response to illness. These emotions can only be handled effectively if each physician recognizes them, and allows enough time for each patient, so that he can become as conversant with the emotional aspects of the patient's structure as he does with the more easily instrumented aspects of the organism.

It is not possible to achieve pathological cure of each breast mass. It is, however, within the responsibility of each physician to offer the maximum relief from suffering, including psychological. This can be done only if the physician is willing to take on this most important, and, to the physician, the most sobering task of medicine—the care of the patient through a terminal illness.

As physicians we do not prevent death; we can, if we are fortunate, help prolong life. We should assist the patient to approach death with dignity and comfort. They have little at such a time but their self respect. The proper assistance in the psychological area helps preserve this.

Treatment of Venous Ulcers of The Leg, Review of 110 Operative Cases. William H. Prioleau, M. D., and Daniel B. Nunn, M. D. (Charleston). *Annals of Surgery* 149, 914-924, June, 1959.

In extensive primary varicose veins and in postphlebitic cases the development of venous ulcers is the result of both the underlying venostasis and the local factors of incompetent perforating veins and the dependency of the ankle. Before definite operative measures can be undertaken, the venostasis must be brought under control and there must be a regression of the inflammatory changes in the region of the ulcer. This is accomplished by supportive boot therapy, the importance of which cannot be overemphasized. The operative procedures consist of interrupting incompetent communicating veins, particularly in the femoral and popliteal regions, excision of varicose trunks and plexuses, and ligation of incompetent perforating veins in the leg. Staging the operation is necessary under some conditions. Excision of the ulcer is seldom necessary.

The injection of sclerosing solutions has been abandoned on account of the risk of causing thrombosis

in the deep veins. Tourniquet tests and venograms have little practical value in the management of the case.

Two hundred and seventeen private cases of venous ulcer have been reviewed. Follow-up data on 110 operative cases have been evaluated. In patients treated by limited vein excision in conjunction with the injection of a sclerosing solution, the results were poor and, in some instances, the condition of the patient was made worse. In patients treated by extensive vein excision through horizontal incisions, there was a high incidence of persistence or recurrence of venous ulcer. The results were greatly improved in those cases in which vertical incisions were used in the leg in order to locate more accurately the incompetent perforating veins.

Patients who have had venous ulcer should be examined at intervals for the development of new incompetent perforating veins and varicosities which may lead to recurrence of ulcer formation.

The application of the supportive boot is well portrayed by four illustrations.

THE EMERGENT MANAGEMENT OF THORACIC TRAUMA

WENDELL M. LEVI, JR., M. D.

SUMTER, S. C.

Introduction

Thoracic trauma has become a progressively more important problem in civilian medical practice in the past twenty years. This can be well attributed to the advent of high speed transportation and the use of motorized equipment in all walks of life. A basic understanding of the emergent treatment of chest injuries is an absolute necessity for every practicing physician, as well as the surgeon. Correct and prompt attention to such injuries can be life saving.

During the second World War, the correct management of thoracic wounds received a great impetus. Great refinements were made in the handling of large numbers of acute battle injuries. Basically, no change has been made in this method of therapy. Shefts⁴ aptly pointed out that when the experience in the battle zones increased, there were fewer thoracotomies performed. He also warned against panic decisions and stampedes to the operating theater.

Parker² in 1947 estimated that injuries to the chest comprised 5 to 8% of the admissions in a busy general hospital. This figure is now probably slightly higher. This paper will try to present briefly, the main types of injuries to the chest and the salient methods of handling.

An understanding of the basic physiology of the thorax is absolutely essential to both treatment and discussion. Normal ventilation and gaseous exchange requires a rhythmic muscular action, a semi-rigid thoracic cage, and an unobstructed airway. The normal intra-pleural pressure on inspiration is -9 to -12 cm. of water and on expiration -3 to -7 cm. Maintenance of this negative intra-thoracic pressure with a completely expanded lung in a dry pleural cavity should be our aim in the management of the injured thorax.

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Discussion

The patient with the injured thorax is most often seen in one of our busy accident wards. Here the most important phase of therapy is accomplished. Immediate evaluation and examination is carried out. The patient is undressed completely. Chest injuries are commonly associated with multiple systemic injuries and a thorough evaluation is essential. One should note especially the color of the lips, and nail beds, the pulse, blood pressure, and respiration. In addition to routine percussion and auscultation, observe for splinting as well as the depth and rate of respirations. Also, note any paradoxical chest motion. Palpate the chest for subcutaneous emphysema, fractured ribs, tenderness, and induration. This can be accomplished in several minutes while a large bore needle or polyethylene catheter is being inserted intravenously. Blood is drawn for typing, matching and cross matching. Shock is practically always an accompaniment of thoracic injuries both from disturbed physiology and blood loss.

One must realize that until the basically disturbed pulmonary pathological changes, such as tension pneumothorax or mediastinal flutter, are corrected there will be no change in the status of the patient despite blood volume replacement and vasopressors. One should remember that narcotics which depress respiration and decrease the cough reflex should be used sparingly. Constant physician attendance during this phase of therapy is mandatory.

Any "sucking" wound should be covered immediately with an occlusive dressing. Smaller wounds may be debrided and closed under local anesthesia. It is important when the patient is to be transported to another location, that the wound not be sutured. Thus, if there is a continued air leak and resultant tension pneumothorax, there will be a route of escape. In the larger wound or traumatic thoracotomy, we see the phenomena

of mediastinal flutter. The collapsed lung falls away from the chest wall on inspiration and moves towards the chest wall on expiration. While the collapsed non-functioning lung increases the normal dead space of the tracheo-bronchial tree, the normal intra-pleural pressure of the contra-lateral lung is also disturbed. In addition, the inadequate filling of the right side of the heart markedly reduces the stroke volume. The patient is unable to evacuate his tracheo-bronchial secretions and marked respiratory distress can ensue. Operative closure of the traumatic thoracotomy should be accomplished with dispatch under general endotracheal or positive pressure face mask anesthesia.

Hemopneumothorax is treated immediately after its diagnosis. Aspiration of as much blood and air as possible, as soon as possible, and as often as is necessary is axiomatic.⁵ X-ray examination of the chest should be obtained preliminarily, if the patient's condition allows. A large bore intravenous needle or catheter should be in place and the patient should have constant medical attendance if transported to the x-ray Department. At least posterior-anterior and lateral and preferably both oblique views of the chest should be obtained, with the patient in the upright or semi-upright position. Serial films can be extremely important in chest injuries. After the diagnosis of pneumothorax, the patient is placed in the semi-upright position. A #18 gauge, short bevel, needle connected to a three way stop cock and a 50 ml. syringe is inserted in the second intercostal space anteriorly, in the mid-clavicular line, with local anesthesia. The air is evacuated until a slightly negative pressure is encountered. In the presence of unlimited air aspiration, an intercostal catheter should be inserted anteriorly in the second intercostal space and connected to an underwater trap bottle. If 1200 ml. or more of air are removed and a negative pressure obtained, it is preferable to insert an intercostal catheter because recurrent pneumothorax and unattended tension pneumothorax are likely. In the presence of constant medical attendance, patients who have had aspiration of as much as 2000 ml. of air with a negative pressure being obtained, can be observed closely and thoracentesis can

be repeated in an hour. Progressive subcutaneous emphysema after thoracentesis and removal of air is best treated by the use of an intercostal catheter. Caution is necessary in the presence of subcutaneous emphysema and no demonstrable pneumothorax because the pleural space may be obliterated by adhesions and trocar thoracotomy is dangerous. Bilateral intercostal catheters are best inserted in the presence of bilateral hemo- or pneumothorax because sudden unattended respiratory embarrassment can occur.

The costophrenic space lies at the inferior angle of the scapula. Aspiration should be performed here with the removal of as much blood as possible. A #15 to #17 gauge short bevel needle is used for aspiration. Thoracentesis in the mid or posterior portion of the axillary line in the 7th through the 9th intercostal space can be performed with the patient in the semi-recumbent position. If large quantities of blood are removed and replacement is not immediately available, then auto-transfusions, as first described by Sanger³ in 1948 using transfusion vacuum bottles, can be lifesaving.

Tension pneumothorax results from a continued leakage of air into the pleural space without route of egress and resultant positive intra-pleural pressure on the side of the injury. As this pressure increases, a mediastinal shift occurs, and a resultant abnormal intra-pleural pressure on the opposite side. If the condition is not recognized and relieved promptly, death due to asphyxiation can occur. Trocar thoracotomy with the insertion of an intercostal catheter should be carried out promptly. If no equipment is available and the patient is in acute respiratory distress, the insertion of a needle or knife into the intercostal space with the release of the trapped air can be lifesaving. A convenient method when a thoracentesis set is not available is to connect the needle to an intravenous set and to immerse the distal portion of the intravenous tubing in a pan of water until a suitable apparatus can be obtained.

The patient with an injured thorax should be placed in the semi-upright or upright position unless hypotension is present. It is well to remember that the presence of subcutaneous

emphysema in chest injuries indicates that there has been a tear of the parietal and visceral pleura with egress of air into the subcutaneous tissue. Although the visceral pleural tear is usually rapidly sealed off, the patient with subcutaneous emphysema should be observed closely for progression of subcutaneous emphysema, pneumothorax, or tension pneumothorax.

Further, the establishment and maintenance of a dry, open airway is of primary importance. Alleviation of pain locally by intercostal nerve block at least two to three ribs above and below the site of injury is extremely important. Adequate coughing, endotracheal catheterizations, and bronchoscopy are used when necessary. Tracheotomy, although not without complications, is of prime importance in chest injuries. It decreases the "dead space", allows easy removal of tracheo-bronchial secretions, and aids in maintaining an unobstructed airway. It should be performed in cases of paradoxical motion of the chest, in semi-comatose patients with concomitant chest injuries, and in any patient in whom adequate tracheal care cannot be obtained with the endotracheal catheter.

Indications For Operative Intervention in Trauma to the Chest.

- 1) A thoraco-abdominal wound or its possibility.
- 2) A large foreign body in the pleural cavity or in the lung.
- 3) A large chest wall defect or traumatic thoracotomy.
- 4) Continued intra-thoracic bleeding.

Other indications which are not absolute are 1) tears in the trachea or major bronchi, 2) suspected esophageal injuries, and 3) suspected penetration of cardiac chambers.

Wounds of the thorax may be generally divided into three types. 1) Closed thoracic trauma, and wounds of the thoracic wall. 2) Combined thoraco-abdominal wounds. 3) Penetrating and perforating wounds of the chest.

Closed Thoracic Trauma: These injuries are due generally to blunt trauma. The most common injury is a fractured rib. Treatment consists of alleviation of the pain and establishing an effective cough. Strapping is considered less

effective than nerve block. Narcotics which diminish the cough reflex should be used sparingly. Simple intercostal nerve block which may be repeated every eight to twelve hours gives satisfactory results. Open reduction may occasionally be necessary for relief of pain.

One of the common complications of this type of injury is the "wet lung", or traumatic pneumonitis. DeTakats¹ *et al* considered this due to reflex motor and secretory stimulation of the bronchial tree which produced bronchospasm and excessive bronchial secretions. It is characterized by a wet, ineffective cough, coarse rales, wheezes, and fever. Treatment consists of obtaining an effective cough and tracheo-bronchial aspiration.

The "flail" or "crushed chest" is a common injury with today's high speed transportation. Immediate partial alleviation of the paradoxical respirations may be accomplished with sandbags. Prolonged fixation of the flail portion of the ribs or sternum may be done in numerous fashions. Cervical tenaculums, towel clips, screw eyes, etc. may be inserted into the sternum or ribs and about 5 lb. traction applied. This method demands complete immobilization of the patient and should be avoided. A method of fixation which allows mobilization of the patient and also movement of the sternum with the ribs is highly desirable, and has been described by Shefts.⁴

Traumatic rupture of the diaphragm, though rare, usually occurs from compressive injuries of the abdomen or costal margins. The left side of the diaphragm is more frequently involved than the right because the larger right lobe of the liver protects the right diaphragm. Difficulty in diagnosis is frequent, because of the overlying hemothorax and the differentiation between a high-lying stomach and a herniated stomach through a lacerated diaphragm. Immediate surgery is not demanded in right diaphragmatic rupture unless the lacerated liver continues to bleed, but suture of the laceration with subcostal drainage should be carried out as soon as the patient is in the optimum condition. This is mandatory in the prevention of bile empyema or pleuro-biliary fistula. Emergent thoracotomy is important with rupture of the left dia-

phragm because of the high incidence of secondary intestinal obstruction, or splenic injury.

Costo-chondral and costo-sternal separations require no immediate treatment other than the relief of pain. Operation may be desirable later for cosmetic reasons.

Tears of the trachea or bronchi result from shearing or crushing injuries of great force. The presenting clinical picture is one of massive pneumothorax or tension pneumothorax, massive subcutaneous emphysema, and mediastinal emphysema. Characteristically with mediastinal emphysema there is shock in the presence of marked respiratory embarrassment, severe substernal pain, and respiratory crunch. The treatment of the associated pneumothorax usually relieves the condition. Tracheotomy and anterior mediastinotomy may be necessary for relief of the mediastinal air. Although the immediate treatment of the tension pneumothorax may alleviate the condition, the persistence of massive pneumothorax despite catheter drainage indicates a large tracheal or bronchial tear. Urgent operative intervention is recommended for repair of the defect and prevention of later complications of either stenosis or atelectasis or both.

Thoraco-abdominal Wounds: These are wounds which involve the pleural cavity, diaphragm, and abdominal peritoneal cavity. A diagnosis or suspicion of penetration of the diaphragm is an indication for surgical intervention. One must always consider the range of motion of the diaphragm and the depth of the costophrenic sulci. Air beneath the diaphragm when present is, of course, indicative of injury to a hollow viscus and it is notable that this finding is present less frequently than suspected. Closure of the diaphragmatic perforation and visceral wound are accomplished and subcostal drainage instituted in the presence of liver fracture. Transthoracic, transdiaphragmatic exploration is the procedure of choice in wounds confined to the upper part of the abdomen. Separate laparotomy and thoracotomy incisions are considered preferable to thoraco-abdominal incisions in wounds involving the lower abdomen.

Penetrating and Perforating Thoracic Wounds: Although these wounds are more

common in warfare, the large Southern community is frequently a fertile ground for these injuries. The agents of wounding are usually knives, icepicks, pistols, and rifles. The colored male is most often involved, and these injuries appear to be more frequent in summer. It is extremely important to obtain information as to the type weapon used and its manner of use. Icepicks which are commonly wielded by women are delivered usually with an overhand thrust. A wound made by an icepick or thin knife blade can often be hard to find, and careful examination of the skin of the chest is essential.

Although from reported experience gained in combat injuries, we know that a bizarre course of missiles is rare, one can never predict with absolute accuracy the path of a bullet. Most often if one lines up the wounds of entrance and exit, the involved organs can be fairly accurately outlined. The greatest amount of damage can be done by secondary missiles such as bone, and by missiles of the highest velocity.

In the case of the large chest wall wound or traumatic thoracotomy, there is no question of indication for thoracotomy. The thoracotomy wound must be debrided and closed.

Shock present in a patient with a penetrating or perforating wound of the chest is usually secondary to blood loss. The mere presence of a hemothorax, regardless of the amount of blood present, is not of itself an indication for thoracotomy. There are three main sources of bleeding in the thorax.

1) Lungs. The branches of the pulmonary vessels in the pulmonary parenchyma.

2) Thoracic wall. The intercostal, subclavian, and internal mammary arteries.

3) Mediastinum. The heart, great vessels and their immediate branches.

Bleeding from the lung parenchyma and smaller branches of the pulmonary vessels is seldom a problem because of the low pressure in these vessels. Also hematoma, and "splenization" of the lung can produce tamponade of the site of laceration. Intercostal vessels can frequently be a source of continued bleeding. The problem of trauma to the heart and adjacent great vessels will not be covered by this discussion.

A suspicion of an esophageal injury requires exploration in most instances. An absolute diagnosis of perforation or rupture of the esophagus can be made only by use of a radio-opaque material, and its appearance outside the esophageal lumen in the mediastinum or in the pleural cavity. Thoracotomy with repair of the injured segment and adequate drainage should be carried out.

Thoracotomy is indicated in the presence of a large intrathoracic foreign body. The position of the foreign body is more important than the size. The hilus of the lung or mediastinum is the most dangerous area. Smaller foreign bodies in the hilar region may be removed electively or when the patient is in the optimum condition. All intrapleural foreign bodies, even though asymptomatic, are preferably removed electively.

Perforation of the trachea and major bronchi as in rupture secondary to blunt trauma is associated usually with marked subcutaneous emphysema and mediastinal emphysema. In most instances of injury to the trachea or bronchi the resultant mediastinal emphysema rapidly dissects the neck, face, and moves retroperitoneally with swelling of the flanks, scrotum, and lower extremities. Pneumothorax

is almost always associated with lacerations of the major bronchi. In the presence of pneumothorax, widened mediastinum, mediastinal crunch, and subcutaneous emphysema, laceration of the trachea or bronchus should be suspected. Tracheotomy is especially applicable in these cases. Operative intervention in cases not controlled by catheter thoracotomy is the same as outlined in rupture secondary to blunt trauma.

By way of summary, a brief presentation has been given in an effort to outline a satisfactory course of therapy in the patient with the injured thorax.

Acknowledgement

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Factors to be considered in the treatment of ovarian agenesis. J. R. Sosnowski, (Charleston) Am. J. Obst. & Gynec. 78:729 (Oct. 1959)

Considering the physiology of secondary sex development and increase in stature, the following program of treatment of ovarian agenesis is suggested:

1. In order to individualize treatment, chromosomal sex, roentgenographic bone age, and thyroid function should be determined in addition to estrogen and gonadotrophin assays.
2. Cyclic estrogen therapy in sufficient dosage to produce secondary sex development.

3. Progesterone therapy if necessary to control estrogen withdrawal bleeding and/or to enhance breast development.
4. Thyroid therapy only if there is clinical and laboratory evidence of deficiency.
5. If a patient having reached pubertal age has demonstrated no increase in stature for the past 6 months, androgen therapy should be instituted immediately, provided the epiphyses are still open. If the patient is demonstrating increase in growth, androgen therapy should be withheld until the patient is within approximately 2 years of the average time of arrest of skeletal growth.

URETEROILEOSTOMY FOR URINARY DIVERSION¹

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E. J. DENNIS, III⁴
CHARLESTON, S. C.

Segmental ureteroileostomy (Figure 1) was popularized by Bricker¹ in 1950 for patients having urinary bladder resections as part of pelvic evisection. Since that time this procedure has also been found to be extremely useful for urinary diversion associated with other conditions. It is relatively free of most of the complications which follow other means of diverting urinary flow.

The procedure itself is not technically difficult. The urine does not come in contact with the fecal stream. Back pressure or reflux is reduced to a minimum by the wide open external stoma. Peristalsis in the isolated ileal segment prevents stagnation of urine. The technique of mucosa-to-mucosa anastomoses between ureters and ileum greatly minimizes ureteral obstruction. Absorption from the ileal segment is clinically insignificant. Therefore, the favorable aspects of the procedure are: (1) the improved results as determined by pyelography, (2) the low incidence of postoperative urinary tract infection, and (3) the absence of hyperchloremia and acidosis.²

The purpose of this paper is to demonstrate by case reports the conditions which can be improved by this type of urinary diversion.

Indications for Ureteroileostomy

Pyrah³ cited the following as indications for ureteroileostomy:

1. Spina bifida with urinary incontinence. (Not to be considered before age ten to twelve years).
2. Certain cases of paraplegia.
3. In pelvic exenteration to avoid a wet colostomy.
4. Vesico-vaginal fistula.

In addition to these we believe that bilateral ureteral obstruction with progressive renal damage can be an indication for this operation.

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3. Professor of Urology.

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Case 1.

M. G., MCH #5940, an eleven year old girl, had repair of a myelomeningocele in infancy. She had urinary incontinence from birth associated with numerous episodes of urinary tract infection for which she was almost constantly receiving antibiotic therapy. There was roentgenographic evidence of reflux of urine in the left ureter and of hydronephrosis. The kidney function was good. The urinary bladder was chronically infected, thickened, and trabeculated by hypertrophy. The urine culture was positive for coliform organisms. She was constantly wet and required fifteen to twenty diaper changes a day. It became impossible for her to carry on normal school work or to engage in any social activities. Ureteroileostomy and incidental appendectomy were carried out on August 5, 1958. Her postoperative course was satisfactory and there have been no episodes of urinary tract infection since operation. She recently graduated from grammar school and is engaging in normal social activities.

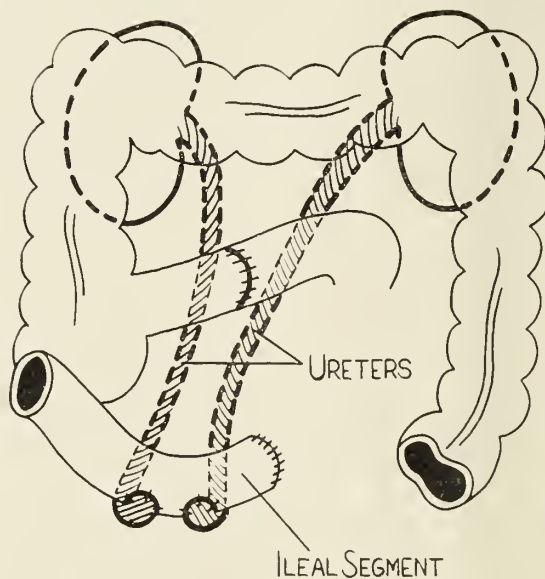


Figure 1

The ureters are anastomosed to a segment of terminal ileum. The distal end of the isolated ileal segment is brought out through the anterior abdominal wall.

Comment: Ureteroileostomy for this type of case has been described by others⁴ as providing a socially acceptable, safe, and convenient means of urinary control. Ulm⁵ suggests that these disabled disconnected bladders need not remain forever useless and cites

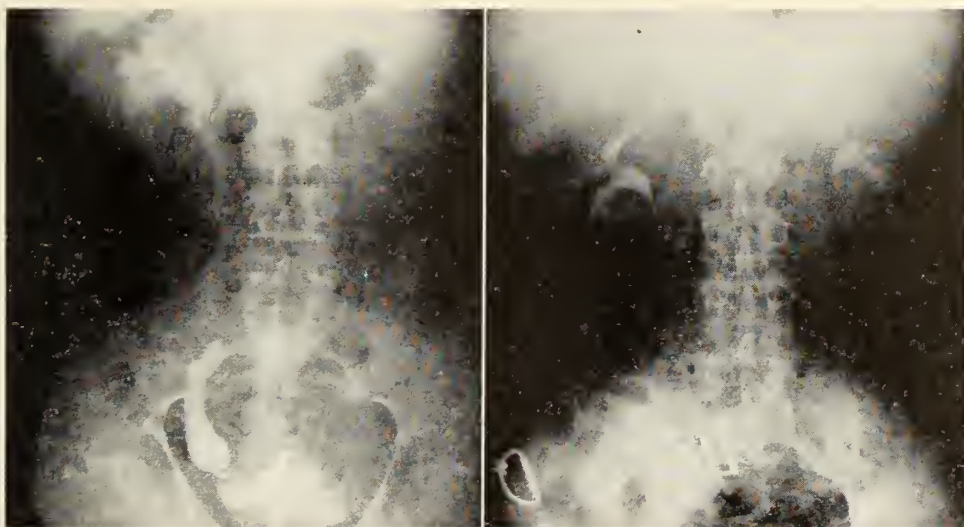


Figure 2.

Case 3. (A) Pre-operative retrograde pyelogram demonstrating hydronephrosis and hydroureter on the right. The left ureter would not accept a catheter.

Case 3. (B) Intravenous pyelogram six months following ureteroileostomy demonstrating normal kidneys and ureters.

a case that was rehabilitated so well by bladder rest that the ileum was anastomosed to the bladder after eighteen months. Urethral sphincter control is regained before this can be done, however.

Case 2.

M. B., MCH #20398, a 37 year old female, sustained a back injury four years prior to admission which resulted in paraplegia. She was incontinent of urine and her neurogenic bladder had a capacity of only 60 milliliters. Because she was constantly wet, rehabilitation on braces was extremely difficult. Ureteroileostomy was performed on January 22, 1959. The postoperative course was satisfactory and ambulation on braces progressed rapidly.

Case 3.

W. B., MCH #11408, a 50 year old white male paraplegic of five years duration with a neurogenic bladder, had been virtually bed ridden and had acute and chronic pyelonephritis. Cystograms, cystometrogram, and cystoscopy with retrograde pyelography were done. These revealed a bladder capacity of 200 ml. and bilateral hydronephrosis and hydroureter. The level of the ureteral constriction was at the uretero-vesical junction. Ureteroileostomy was performed on February 3, 1958. Other than urinary tract infection immediately postoperative, this patient has been free of pyelonephritis since discharge from the hospital. Intravenous pyelograms done six months later revealed normal kidneys and ureters. (Figure 2).

Comment: Cases 2 and 3 were paraplegics who could not be rehabilitated on braces be-

cause of continuous wetting. The ordinary types of urinary drainage by catheter and condom drainage were ineffective. Case 3 was in incipient renal failure because of progressing renal damage. Both were improved remarkably by the ureteroileostomy.

Case 4.

I. C., a 57 year old female, was treated one year prior to admission with intra-cervical radium for carcinoma of the cervix, stage III. She was incontinent of urine for almost a year. Repeated biopsies of indurated adnexal tissue were negative. Intravenous pyelograms were negative. A vesico-vaginal fistula was clearly demonstrated on physical examination and by cystoscopy. There was fixation of the pelvic organs and marked edema of the urinary bladder and rectum. Repair of the fistula was not feasible. Ureteroileostomy was performed on July 16, 1958. The postoperative course was satisfactory and the patient has been much more comfortable since operation with this type of controlled collection of urine.

Case 5.

J. P., MCH #15852, a 45 year old male, had electroresection of a carcinoma of the urinary bladder in November, 1956, in another hospital. This was followed by a 30 day course of low voltage roentgen therapy. Because of almost exsanguinating hematuria and dysuria, he was referred to the Medical College Hospital. Cystoscopic examination in June, 1958, revealed a large sessile tumor just within the vesical neck which was examined by biopsy and found to be transitional cell carcinoma of a moderate grade of

malignancy. Intravenous pyelograms revealed hydronephrosis bilaterally. On July 2, 1958, laparotomy was performed. The bladder tumor was not resectable so a ureteroileostomy was done because of obstruction of the ureters and hemorrhage from the tumor. Following the operation, the patient got along well for a few months but subsequently developed severe pelvic pain. The neoplasm progressed rapidly and death occurred one year following operation.

Comment: At the time of operation, there was rapidly developing ureteral obstruction due to neoplastic involvement of the trigone. It was our belief that had not ureteroileostomy been performed, he would have succumbed much sooner from obstructive uropathy and uremia or from hemorrhage.

Case 6.

E. H., a 51 year old female, had a supravaginal hysterectomy in September, 1958, in another hospital. The operative specimen contained epidermoid carcinoma. She was admitted to the Medical College Hospital in November, 1958. Because conditions in the pelvis were favorable, the decision was made to do a pelvic evisceration and ureteroileostomy. This was carried out on November 12, 1958. Carcinoma involved the left ureter at the uretero-vesical junction necessitating high division of this ureter. She developed a wound infection and leak of one of the uretero-ileal anastomoses. These complications resolved and since discharge she has gotten along well.

Case 7.

M. W., a 50 year old female was admitted to the Medical College Hospital in April, 1956. She had been treated elsewhere for carcinoma of the cervix, stage I. Biopsies of the cervix revealed recurrent epidermoid carcinoma. Intravenous pyelography demonstrated bilateral hydronephrosis and hydroureters. She was having severe pelvic pain controlled only by large doses of narcotics. On May 25, 1956, pelvic exenteration with urinary diversion by ureteroileostomy was performed. The postoperative course was satisfactory. Narcotics were no longer necessary for relief of pain. Intravenous pyelography one year later showed normal kidneys and ureters.

Comment: Both cases 6 and 7 demonstrate the original application of ureteroileostomy. It has been found to be a far more satisfactory means of urinary diversion than the wet colostomy formed by implantation of the ureters into the segment of descending colon brought out through the abdominal wall. The complication encountered in Case 6 was believed to be due to tension on the left uretero-ileal anastomosis caused by a short proximal ureteral segment and edema of the ureter at the level it was divided. Drainage was effectively established through the perineum until the

fistula closed. Case 7 obviously exemplifies the maximum benefit that can be obtained from pelvic exenteration. There is no evidence of recurrent neoplasm in this patient. It is important that she has had no difficulty with recurrent urinary tract infection. This has unquestionably been the major complication as well as the cause of death in many of the patients undergoing pelvic exenteration who had urinary diversion by some other method.

Discussion

Segmental ureteroileostomy has been widely accepted as a means of satisfactorily diverting urinary flow to the exterior. It is safe, socially acceptable, and convenient. The patient keeps a collecting receptacle over the ileostomy opening at all times. The Rutzen bag, the Lapidus device, and the Con-Seal enterostomy appliance are all satisfactory devices for collection of the urine. These receptacles can be emptied at anytime without removal. Re-application is usually necessary every two or three days.

The segment of ileum serves as a renal protective mechanism since the active peristalsis prevents stasis and minimizes re-absorption of the urine. Eismen and Bricker⁶ showed by infusion of ileal segments that both chloride and urea are absorbed appreciably but clinically they did not find this absorption to be a problem.

Stamey and Scott⁷ found no evidence of diuresis from urea absorption or chronic potassium loss in 14 patients. The short length of the ileal segment, the rapid evacuation of urine by peristaltic action, and the low concentrations in the urine prevent excessive electrolyte absorption and symptoms of toxicity. Although a short ileal segment is advocated by most authors, Bill *et al*⁴ used segments measuring 35 and 22.5 centimeters in two patients without evidence of electrolyte abnormalities six months after operation.

Klinge and Bricker⁸ found that the average amount of the segment fluid volume emptied at one time in the supine position is highly constant between 56 and 63 per cent of the total volume. In the cases presented we have observed no evidence of toxicity from re-absorption. In several who were re-admitted for unrelated reasons, electrolyte determina-

tion were found to be within the normal range.

Technique

Our technique has been essentially that described by Bricker.⁹ All patients are placed on sulfathaladine for five days and neomycin for one day pre-operatively. A left paramedian incision is made beginning just above the umbilicus and extending inferiorly to the symphysis pubis.

A segment of terminal ileum with a good blood supply measuring 8 to 10 inches in length is selected. Before this segment is isolated, the right and left ureters are identified and divided several centimeters beyond the level of the iliac arteries. The left ureter is brought under the sigmoid mesocolon through a tunnel in such a way as to avoid angulation. Mobilization of the ureters for distances more than six centimeters proximally is avoided so as to prevent impairment of their blood supply. The selected segment of ileum is isolated by transection of the intestine at the proximal and distal ends. The distal end of this segment is usually located approximately five inches from the cecum. The incisions in the mesentery must be short and the base of the mesentery to the ileal segment should be kept as wide as possible. Continuity of the ileum is re-established by a two layer end-to-end anastomosis. The defect in the mesentery is closed. The proximal end of the ileal segment

is closed with a double row of inverting sutures. (Figure 3)

The most important part of the procedure is proper end-to-side, mucosa-to-mucosa anastomoses between the ureters and the ileum (Figure 4). Both ureters are sutured to the adventitia of the ileum with 4-0 silk sutures. Openings of the size of the ureters are then made in the ileal wall, usually on the anti-mesenteric border. An internal row of interrupted 4-0 chromic catgut sutures are then placed through the full thickness of ureter and intestinal wall. As many of them as possible should have the knot tied on the interior of the anastomoses. The anterior layer of fine silk sutures are placed in such a way that as little ureter as possible is turned in.

The external stoma is created by excising a circular piece of the entire thickness of the anterior abdominal wall at a point midway between the umbilicus and the anterior superior spine of the ileum. The distal end of the isolated segment is brought through this, everted, and sutured to the skin. The right lumbar gutter is not closed. The tunnel created between the mesentery of the isolated segment and the left ureter must be closed to prevent herniation of bowel through this defect. A bag

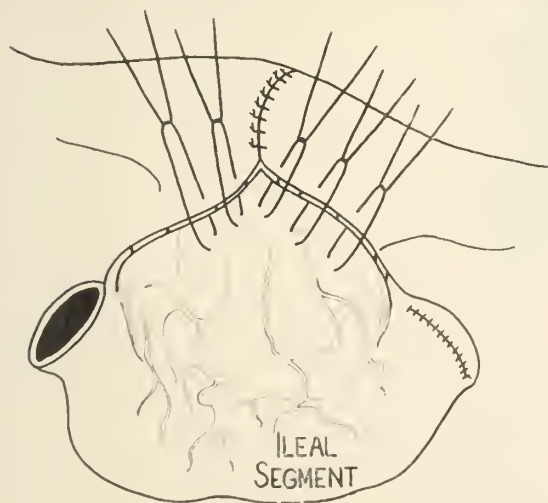


Figure 3.

Continuity of ileum is re-established by two-layer end-to-end anastomosis. The mesenteric defect is closed. The proximal end of the isolated ileal segment is closed with inverting sutures.

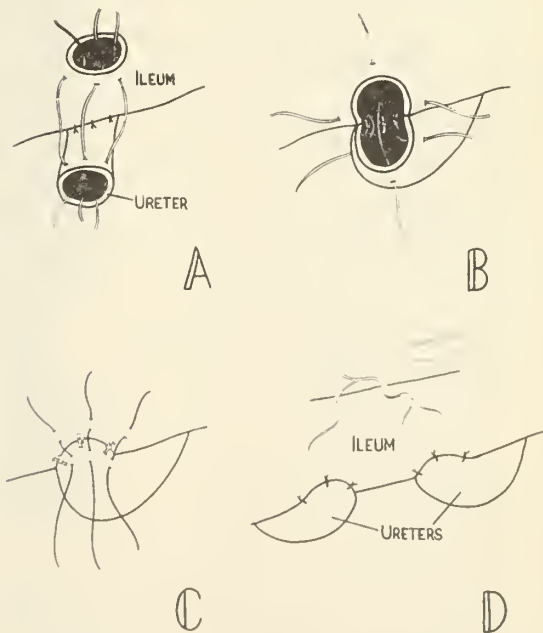


Figure 4.

End-to-side mucosa-to-mucosa anastomoses between ureters and ileal segment.

may be applied over the stoma to the skin when the operation is completed.

Summary

The indications for ureteroileostomy for urinary diversion include spina bifida with urinary incontinence, certain cases of paraplegia, in pelvic evisceration, vesico-vaginal fistulas which cannot be repaired, and in certain cases of bilateral ureteral obstruction.

Seven cases have been presented to demonstrate the application of this procedure. The procedure itself is not difficult technically. The incidence of postoperative urinary tract infection is low. Hyperchloremia and acidosis have not been a problem clinically. Renal function is protected by the peristaltic action of the ileal segment, the lack of reflux, and the absence of contact with the fecal stream. The technique has been described briefly.

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*Dr. Jacob De La Motta
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Born in Savannah, Ga.
Died in Charleston, S. C.*

MUSIC THERAPY IN THE PSYCHIATRIC TREATMENT PROGRAM

ANN WHITWORTH HOWE*

In surveying the professional field of music therapy, attention should be called to The National Association for Music Therapy. This is an organization of doctors, educators, musicians working in rehabilitation activities, students preparing for the profession, and persons interested in supporting its work.

Music volunteers are used extensively in all kinds of hospitals. In hospitals for the tuberculous, and crippled, and in short term general hospitals, their work is mostly confined toward entertainment, in long term and custodial institutions, this activity is expanded to teaching, coaching music groups and arranging auditorium shows. Volunteers are usually screened and indoctrinated under supervision. They are often sponsored by service organizations, notably patriotic groups, the American Red Cross, or the National Federation of Musicians. Much of this work is of professional caliber. Where funds and personnel are limited, volunteers are often depended on for the hospital's entire program, under medical guidance. Substantial donations of instruments and training scholarships have been made possible by national music fraternities and civic organizations.

The term music therapy has been defined by The National Association for Music Therapy as: "The use of music as an adjuvant therapeutic tool available to the doctor who prescribes the total plan for helping the patient to better health." It is one that has both breadth and depth of emotional appeal, and one which can be subtly used to influence attitudes and moods at a non-verbal level. While the greater use of institutional music is found in mental institutions, this thinking applies not only to this area of mental illness but to the fields of physical handicap and illness as well. Tedium, discouragement, and feelings of exclusion are the usual by-products of all illness, and the door to the alleviating satisfactions found in self-expression as wide for one kind

of patient as for another.

All peoples have cherished music because of its unique necessity to man's emotional and social well-being. It has offered appropriate emotional commentary on those chief circumstances of his life which most distinguish him as a human being. From the lullaby to the dirge, music has spoken for him, and to him, when words could not. Music comforted him, has inspired him. It has enhanced his religion, enriched his relationships, and clothed reality with "delightful illusions" so that he might feel freedom and experience pleasure.

By far the greater part of music has some psychological or sociological aim in view other than the purely aesthetic. Music whose primary purpose is other than the aesthetic is called functional music. One phase of functional music is music therapy, the utilization of music in the rehabilitation of the sick. Music readily lends itself to therapeutic purposes. Its usefulness in therapeutic procedure rests upon several principles, among which are the following:

1. Because of its subjectiveness, music becomes the most intimate of the arts, yet it is most adaptable of the arts because it functions in a multitude of ways for nearly everyone. For these reasons music has wide application even in clinical usage.

2. Music dissipates "aloneness", at least for the time of the activity, by re-establishing emotional ties.

3. It is sound without inherent threat, rather than an object that is responded to in music, therefore music becomes a part of reality to be enjoyed and trusted without fear.

4. Form and contents are one in music. Feeling of form is a feeling of relationship. This in turn, then may bring about a feeling of security.

5. Music participation, either listening or performing, provides an easily accepted segment of reality, and thus a platform of reality whereon both patient and therapist may stand

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without disagreement and in confidence.

6. The performance of music generally induces in the performer a beneficial sense of accomplishment and gratification.

7. Music, because of its power to move man deeply, affords an aesthetic control of behavior. Judicious application of music may thus enable a patient to behave on a higher plane.

8. Music is a truth as its universality testifies; by consensus it also has beauty. In music therefore is found a fusion of truth and beauty at a non-verbal level. This value may be adopted by the individual as his own.

9. Music is basically a means of communication and often succeeds where less subtle means fail.

10. Music allows patients a cooperative activity without conflict, therefore making for resocialization.

11. Music is only a part, although an important part, of the therapeutic milieu.

12. Music offers for the patient a Gestalt or sensory-motor-emotional and social components.

13. Moods elicited by music derive from the tender emotions. Music may, therefore, effectively arouse that which is often at low ebb in patients, i.e., the various manifestations of love. This makes possible the transfer of positive feelings for music, to the therapist.

14. Despite the intrinsic importance of music, in a clinical context it is a means toward the more important aim of establishing therapeutic relationship between patient and therapist.

15. The introduction of selected music creates a warm and pleasant atmosphere which helps to induce positive attitudes on the part of the patient toward the hospital environment. This function of music holds true for the medical personnel as well as the patients. Music thus makes an important contribution to morale and patient care.

I have mentioned some of the principles of music therapy and now would like to set forth how music therapy functions in the psychiatric hospital. Throughout the entire country there has been an increasing interest on the part of all thinking citizens regarding the care of the mentally ill and the improve-

ment of their state hospitals. Increasing interest in the therapeutic atmosphere of the hospital has come about through a change from interest in symptoms to interest in the patient's total personality. Recognition that emotional and mental illness may involve every area of the patient's life situation has led to the collaborative activity of the clinical teams, utilizing medical resources towards the patient's personal, social and vocational rehabilitation. The patient's return to the integrated community living, which in the broadest sense is the goal of psychiatric treatment, is facilitated by the collaborative process. There has been a desire to utilize every reputable method of treatment at the South Carolina State Hospital and we are happy that music therapy is now available.

In many outstanding psychiatric hospitals where nurses, attendants and special therapists are expected to carry out a major portion of the treatment and where therapy (rather than mere custody) is the regular practice, it is essential that all persons who come in contact with the patient should maintain a uniform attitude insofar as possible. The physician communicates specific instructions as to medications and activities and designates attitudes to be assumed toward the patient by all members of the hospital personnel.

From the tentative diagnosis and outstanding symptoms, the nurses and therapists gain knowledge of the patient's behavior, attitude and symptomatology which help them in their care of the sick patient. The personal information given is of value in planning occupational, recreational, educational, and music therapy programs by which these adjunctive therapies are able to contribute to the formation and maintenance of a consistent and uniform plan of therapeutic management for the patient.

To outline an effective and broad therapy program, knowledge of normal and abnormal behavior patterns is needed, so that the therapist can talk the language of the doctor who in the hierarchy of the hospital is the guide. Sound specialized knowledge in the music area itself is of course essential for the music therapist to interpret his medium adequately to the physician, for the best machine on a shelf, or working at half capacity, is of little

value. This combination of control of the medium plus proper background in psychology and therapy principles should insure maximum productiveness in laying proper ground work.

The personality of the therapist plays a vital role in hospital work so that he should be both mature and emotionally stable. As for personal qualifications for a music therapist, the National Association for Music Therapy offers as follows: "Good physical health and stamina are essential. Emotional stability is extremely important and no emotional mal-adjusted person should consider or be advised to enter this field. The music therapist must possess patience, tact, and a genuine desire to help others. The ability to work with others cannot be over-stressed. The successful therapist is frequently one who has faced the problem of choosing between a musical career, teaching, or a career as a nurse or doctor. In music therapy one is able to combine these ambitions in one profession."

In general, the music therapy program at The South Carolina State Hospital falls into five classifications:

1. Workshop activities, which are individual, small ensemble groups, and study groups.
2. Large group activities, which include coached participation, rhythm bands, passive listening and active listening.
3. Music entertainment other than in the auditorium and music rooms.
4. Ward programs—with patient participation, music supplied on request for special affairs anywhere in the hospital.
5. Background music with treatment and music during patient's meals. Combos for dances, or dance orchestra for weekly dances. Patient recitals, community sings, and classes in music appreciation and theory, weekly.

The success of the job demands that certain basic adequacies be allowed: adequate space to provide physical comforts with room enough to work and some degree of attractiveness in the surroundings, adequate tools, by purchase or donation, with privilege of proper care and repair, adequate personnel to implement, helpers on mechanics of supervision and escorts who are agreeable. Too little help in a broad scope program means curtailment or

exhaustion of the workers; too much leads to confusion of effort.

Each institution needs its own suitable music programming, fitting to the overall plan of doctor and administrator. These possibilities must be explored by the music therapist, with imagination and flexibility. From the man playing a kazoo in a back ward rhythm band to the lead fiddle in the dance orchestra, from soothing "homespun" bedside program to the well performed anthem of the robed choir at Sunday service there is a broad gamut of possibilities for making the institutional music program vital.

In music therapy lies one answer also to many of the problems of institutional living. Most institutions are of necessity large—music is a leavener which often brings a feeling of freedom and release. Discouragement and lethargy are ever present deterrents to proper attitudes; the arts and the cultural activities offer fine avenues of approach for defeating these enemies of healthy emotional tone.

The cultivation of music appreciation and talents will fortify those who go back to problems of living outside. It will bring comfort and pleasure to those who must remain inside. At a time when life seems to the patient to have stopped, when long periods of time must be lived under enforced institutional care, cultural interest are antidotes to discouragement, to fear, and to anxiety. For broader horizon, for richer emotional tone, for greater joy in living, institutional music programs can well be utilized as a sound public investment in good health.

Dr. William C. Menninger (of one of the country's most famous psychiatric institutions) has said: "Psychiatric hospital care should afford specific and continuous treatment, specific in that it is directed toward meeting the conflict of the individual, and continuous in that every contact that the patient makes throughout every day should guide him toward the same therapeutic goal".

These examples come from experiences with this kind of music therapy in the milieu therapy program at the Menninger Clinic Psychiatric Hospital, in Topeka, Kansas.

Case 1. A boy, aged 19, had uncontrollable outbursts of hostile, destructive behavior, boastfulness,



and an attitude of contempt for other people's opinions and rights. Coupled with this lack of control of hostility was an intense need to be accepted by the group and a longing for affection and warmth which he had never known. There was no question but that the hostility, directed toward both parental and sibling figures, prevented just the acceptance he needed so badly. He played a band instrument, and it was felt that use could be made of his interest in music to supplement the therapeutic program, which was designed to foster control of the hostility and increase the gratification he could get from inter-personal relationships.

To this end, participation in two aspects of the music program was prescribed by his physician. One of these consisted of daily lessons and practice at the piano with a music therapist who was a warm, motherly person. With a combination of gentleness and firmness she was able to engage his attention for increasing periods of time. She first chose exercises and selections in which he could pound and bang on the piano, and then gradually modified these as the need for such outlets diminished. Duets afforded her an opportunity to demonstrate to him the pleasure to be attained from cooperative efforts. When his aggressive behavior was sufficiently under control to permit more activity with the groups, he became a member of the patients' dance band. This was an activity he was interested in, yet he soon discovered that his behavior was so disruptive to the group that he could not continue as a member unless he was able to modify it. Helpful suggestions from the therapist and opportunities for leadership in those areas where his skills permitted helped him overcome the initial difficulties. Then he found the other patients in the band became genuinely friendly and even admiring of his musical ability. The relationship between control of hostility, gratification in personal contacts, and

praise for real achievement was clearer from the experience itself than words alone could ever convey.

Case 2. A young woman, aged 23, had a different but no less useful experience with music therapy. She was impulsive, demanding, aggressive, pushed people's patience to the limit, and constantly provoked rejection. Hurt feelings and sulky behavior would follow, with no awareness that she had done anything to disturb, annoy or provoke the other person. Consequently, everyone was viewed as hostile, an enemy, and the cycle was started again. This had been going on all of her life and would be seen in its greatest intensity in relation to her mother, who rejected her.

Our first therapeutic goal was to increase her awareness of the ways in which she contributed to her own unhappiness, of how her behavior affected other people, of how she provoked rejection and then reacted to it with more hostility. Only after this goal was reached did we feel we could begin to help her understand the reasons behind her behavior and how she might change it to more satisfying ends. It was hoped that her interest in music could be used in achieving these goals.

Piano lessons were prescribed, not to increase her musical knowledge or ability, but to use the relationship with the music therapist to call her attention to the various facets of her behavior as they appeared during the lesson. In the course of treatment there was ample opportunity for this. The therapist's patience was tried again and again; the same simple mistakes were made repeatedly, pointed out to her, corrected, made again, then blamed on the therapist. She insisted on skipping necessary preliminaries and plunging into music far beyond her ability. If denied, she felt abused and deprived; if permitted to count failure in this way, she was not sufficiently protected. The hours for teaching and practice time were either

inconvenient or insufficient. Within the music therapy situation, one character trait and behavior pattern after another was directed to the patient, not to the music, and she dealt with things on the spot as they happened. Why these all appeared in such concentrated form in relation to music lessons it was difficult to say, but its value was obvious. Instead of many people dealing piecemeal with the problems, in a variety of situations, it was possible to concentrate the confrontations and suggestions in one person and one situation with all adjunctive to it. One might even say the psychiatrist was an adjunctive therapist in this case.

Case 3. A young man in his twenties was a very talented violinist. It was his talent on which his family doted and which was exploited by them. Over a period of a few years he had withdrawn from social contacts, developed many physical complaints, and begun to drink heavily. As his family's concern mounted, his symptoms increased. In the hospital it was necessary to help this young man find gratification by means other than his illness and the worry it aroused in his parents. It was also necessary to avoid any further exploitation of his talents except for his own gratifications. Playing for pleasure, his own pleasure, became the important thing and if it was not enjoyable, there was no need to do it. At the same time his symptoms afforded him no gratification while in the hospital, and a gradual substitution was made.

Case 4. An isolated, almost mute boy was unable to accept any companionship or to respond to friendly overtures. Listening to phonograph records in the presence of a music therapist led slowly to his being able to request his own selections. Occasional attendance at record concerts led him into contacts with other people. He was gradually able to extend these contacts.

It can be seen from these few examples that music can mean different things to different people, and in psychiatry perhaps more than in any other branch of medicine, the person rather than the disease must be the focus of attention. How could we possibly go about prescribing this kind of treatment for schizophrenia for example? Would we mean the schizophrenic who is withdrawn and mute, or he who is hostile and destructive, or suspicious and delusional, or guilt-ridden and depressed, or alcoholic, or grandiose, or hypochondriacal, to mention a few? Diagnostic labels are few but there is infinite variety in people.

Although the actual form of music therapy itself was not the same for any of the patients described in the example, difference in form is not the basis of its individual therapeutic value. Even the same activity can serve different ends. As an extreme yet simple illustration,

let us take the learning of a new and standard piece of music, say Beethoven's familiar "Minuet in G". For the impulsive antisocial person it could be a stepping stone to conformity. There is a right way to play it and a wrong way. For the person who needs to find security in orderliness and perfection, attention can be directed to the correctness of the notes, and to the following of the dynamic markings, the pedalling, and the fingering, it can be a creative experience, a way of bringing pleasure to others through public performance, a way of establishing contact through sharing a common and familiar memory, and so on with many variations.

This is a partial answer to the question as to the difference between musical activity and music therapy. Music is therapy when it is subordinated to a definite treatment goal, when it is used in such a way as to fulfill a specific need, provide an outlet for tensions, or serve as a focus for personal relationships. But this would seem to present a paradox. Beethoven's "Minuet in G" is Beethoven's no matter what use is made of it, no matter whether the playing of it is a pleasure or a chore, a way of creating, or a way of receiving attention. How then can Beethoven's "Minuet" cure anyone?

In the answer to this question lies the essence of this type of music therapy; and, the answer is as simple as it is startling—the music alone does not cure. The music therapist, using the flexible medium of his special field, is the real therapeutic agent. It is he who uses the music in a particular way to achieve the particular treatment goals; thus, helping the patient make a real therapeutic experience out of what would otherwise be work or recreational activity. The atmosphere that the therapist creates, the relationship he establishes with the patient, the particular direction in which he turns his attention, change music activity into music therapy.

Mastery of the medium and understanding of the rehabilitation hospital program prepare the therapist to use a broad gamut of musical activities. Which particular ones are suitable will depend on the kind of institution and the kind of patient. For patients with tuberculosis a passive approach is needed, as with hospital-

wide radio with ear-phones, occasional quiet programs, music quizzes and simple instruments to play such as the auto-harp. For slow, retarded groups much elementary rhythm work is required, musical games which are simple, and dancing. For the crippled, such performances is indicated as can be mastered with coordination. In correctional institutions the potential socializing forces of music and the satisfaction of developing new talent are important. For mental hospitals, a broad range program is possible touching every phase, diversional, educational, spiritual, and as constructive occupation. The same values are potential for work with the blind or deaf with special approach for making contact and fitting the activity to the individual capacity.

The relationship of the therapeutic purpose and music assignment must be understood by the worker if he is to be an effective member of the therapeutic team. He must be at home with the professional terminology used in referrals, reports and histories. In mental illness he must know when it is good for the patient to be featured and given a spot of importance, when it is better for him to accept being only part of a group. He must recognize how to help a shy person find security in an activity, and an aggressive one to accept the disability of concerted effort with others. In the areas of neuromuscular and orthopedic handicaps he must understand muscular and joint functions, perceptual and sensory functions, and disabilities, and the danger of over-fatigue. He must realize the extent of possible improvement and know how to manipulate the musical activity to help the patient release naturally and constructively. Understanding these principles of therapy is of equal importance with musical skill.

The Music Therapy Staff of the South Carolina State Hospital consists of a Director and Assistant Director. There are regular weekly classes in music appreciation and music listening, classes in theory and sight-singing, ensemble groups and various combos, music in the dining room, private lessons on various instruments and chamber music rehearsals.

Recitals are given in the auditorium. A patients' music club has been formed whose members strive to maintain the highest

standards, that they may edify and educate others to an enjoyable appreciation of the beauty and cultural value of music in the hospital program.

The orchestra has been formed to provide a means of establishing a co-ordinated therapeutic, cultural experience for the patients; a means for acquainting the public directly with the problems of mental illness by integrating town musicians with hospital musicians; a presented opportunity for hospital personnel to share a common meeting ground with the patient thereby establishing closer relationships with them and the volunteers involved.

The South Carolina State Hospital is one of the few public mental hospitals in the South to have music therapy interns. The training program here accepts students for a six months clinical training internship during which psychiatric nursing classes are attended, assistance given in all areas of the hospital in order to receive a broader ancillary outlook, and opportunities afforded to participate in the research, training and development program made possible by the National Institute of Mental Health Grant.

As basic requirements in the rehabilitation of patients, various activities are arranged in the music therapy schedule. The music therapy club of about 20 patients, guided by the music therapy director, meet to discuss ways and means of promoting and encouraging equitable relationships between patients and hospital personnel in the establishing of a therapeutic environment. Utilizing group material, functions of the music therapy program include club meets, weekly ward and dining room music, listening hour, music appreciation, rhythm band, symphony orchestra, a cappella rehearsal, community sings, coached groups, rehearsals with various instruments, in addition to individual lessons. Medical interns, chaplains, affiliate nurses and music therapy trainees have opportunities to test and evaluate music therapy principles in varieties of treatment situations in order to learn their degree of applicability in the treatment program.

Music Clubs or other organizations such as the Lions, the Sertoma, the Rotary, the Junior League, the Women's Club and interested

groups, as well as professional groups, have in various communities in the past, all undertaken to do their part in helping to contribute the costly equipment, such as pianos, tape-recorders, accordians, band and orchestra instruments or victrola records, and even household furnishings to make our rooms appear warm and homelike.

Civic groups or persons who are civic minded can assist in the establishment of our South Carolina Hospital Music Therapy Department. Material support of projects can

run from small specific projects to large highly specialized programs impossible to launch without the sponsorship of foundations or organizations of size and serious purpose. This has been successfully undertaken for many hospitals where music therapy was just being established. Trained and skilled professionals must plan and direct any method in the treatment program, but the assistance and active participation of unselfish and interested men and women is of tremendous value.

THE GREENVILLE COUNTY MEDICAL SOCIETY HISTORICAL SKETCHES GREENVILLE'S HOSPITALS

J. DECHERD GUESS, M. D.

The first hospital to be operated in Greenville was called the Soldiers Rest. It remained open for three years, 1862-1865. It was maintained by the community for sick and wounded Confederate soldiers.

In 1872, ten years after the opening of the first hospital, the second hospital in Greenville opened. It was a private, small hospital, or infirmary, which was owned and operated by Doctors James Marshall McClanahan and George E. Treseott. It must not have been a successful venture since it remained open for only one year.

The first hospital to occupy a building designed and built for it was the Earle Sanatorium. It was built and operated by Doctors T. T., Curran B., and Joseph B. Earle. It had 18 beds and a well equipped operating room. It was primarily a surgical hospital, operated to care for the growing surgical practice of the Earles. It continued in operation for 12 years and closed in 1911. Its closing was a gesture of goodwill and support to the new City Hospital, the precursor of the Greenville General Hospital.

Dr. W. C. Black operated a hospital with

14 beds and an equipped operating room during almost the same period. He also closed his hospital in 1911, and transferred his work to the City Hospital.

These two private hospitals made of Greenville an early medical center. Dr. Black and Dr. Curran Earle were equally ambitious. There was always considerable rivalry between them, and each possessed traits which gave the other some advantage. Dr. Earle was always the gentleman of the old school. He was very punctilious, quiet spoken, immaculately dressed, and very gracious. However, he was quick tempered and easily offended.

Dr. Black was rough hewn, rather blunt at times, overbearing, always a little careless in his dress, and he always had a cigar stuck deeply in his mouth. However, he was big hearted, and he was the medical hero of many people in the environs of the city and even more in the hills and mountains of the countryside.

General surgeons were accepted by their colleagues and by the public at that time as a superior type of general physician. This was, and still is to a considerable extent, a carry-over from the time in ancient Greece and ancient Rome when doctors were divided roughly into two groups, namely, physicians

This is the seventh of a series of articles, adapted from the book *A Medical History of Greenville, South Carolina*, written by the same author, and which was published by the Greenville County Medical Society in 1959.

who were also surgeons, or who did surgery, and physicians who did not. Surgery was not a specialty. It was only the more ambitious physician, with the greater initiative, and who was the more studious, who prepared himself, even in a limited way, to attempt more than empirical medical practice and more or less conservative midwifery. These men became surgeons.

The Corbett Sanatorium was built in 1908. It was operated by a corporation called The Southern Oaks Sanatorium Company. Its capital stock was \$15,000. L. D. Corbett, Dr. J. Adams Hayne, and Dr. J. R. Rutledge were the incorporators. It was operated for the treatment of alcoholism. It had continued under its original ownership for about four years, when financial difficulties caused it to close. The county medical society was offered an option on the building, but it showed no interest. The Women's Hospital Board of Greenville, however, saw an opportunity, and took up the option and re-opened the hospital as Greenville's first general hospital on January 10, 1912. In the first month of operation, the hospital received 46 patients and discharged 31.

The purchase of the Corbett building and its re-opening as a general hospital was the culmination of 16 years of continuous effort to establish a general hospital in the city.

Interest in a public hospital was first aroused by two cases of typhoid fever which occurred in a group of transient workers who were living in boarding houses in the city. There was aroused a fear of an epidemic of typhoid—an occurrence which was not rare in South Carolina at that time. In 1895, in an editorial in the *Greenville Mountaineer*, it was said, "A charity that has become an absolute necessity is a city hospital with a casualty ward." A movement to establish such a hospital had been started about that time by the Knights of Pythias. In 1896, at a well attended, citizens mass meeting, the Greenville Hospital Association was organized. A most prominent and civic minded citizen, Mr. George W. Sirrine, was made chairman. A short time later a ladies auxiliary to the hospital association was organized and began efforts to raise money. Some five years later, the auxiliary was re-

organized as the Women's Hospital Board of Greenville, probably because the original hospital board had been so dilatory in its efforts to establish a hospital. That same year, the auxiliary rented a room in the Earle Sanatorium for one or two charity cases.

In 1909, the Charity Aid Society, another women's group, was founded and it petitioned the city council to appropriate funds to operate an emergency hospital for the care of charity patients. The following year a small charity ward of two or three beds for the treatment of destitute sick people was opened in a room at the Salvation Army Citadel. The Salvation Army furnished food, shelter, and heat, and the Aid Society paid the nurse's salary. There was also a small operating room and a room for the nurses. An out-patient clinic and dispensary were maintained as a part of this elementary effort.

The opening of the City Hospital in the remodeled Corbett Sanatorium building was a tremendous forward step. After the opening, the Women's Hospital Board again became an auxiliary, this time the Hospital Auxiliary. As such it undertook the overseeing of house-keeping problems in the new hospital. The hospital was operated by a board of prominent citizens.

It had always been the wish of the Women's Hospital Board that the city should own and operate the hospital. The facility had been offered to the city for \$20,000 in 1913. This was about one-half of the actual value of the plant. Finally, in 1917, the city did buy the hospital from the Greenville Hospital Association and refunded all contributions which had been made toward the original purchase and remodeling. The Women's Auxiliary applied its refund toward the construction of the first nurses' home. This was completed and occupied in 1919.

Now the hospital was under city control. Already the need for enlargement was pressing. The closing of both the Earle and the Black hospitals had directed the greater part of local surgical cases, both private and charity, to the new hospital. A bond issue for funds for enlargement was voted, and a new main building was completed in 1921. The hospital

now had 125 beds. The nurses' home was enlarged in 1928.

The pressure caused by a growing population, a lessening fear of hospitals, and a better trained medical profession did not let up. In 1935, the J. Marion Sims memorial wing was completed. This added 75 beds, in relatively deluxe private rooms. The hospital now had 200 beds. Because of the unspoken influence of these deluxe rooms, in a specially named wing, as contrasted with the real or imagined connotations of the name, "City Hospital," the name of the hospital was changed to the Greenville General Hospital.

In 1938, a wing was added to the nurses' home. In 1939, a surgical wing was added to the hospital. In 1940, the Sirrine Ward was completed. The hospital now had a capacity of 275 beds. It was again enlarged in 1944 to 343 beds by the addition of a basement and two floors.

The hospital was still too small. In 1945, the first action toward a major expansion was taken. A special advisory board of prominent citizens was set up to study and direct the movement. In 1947, this board proposed that the hospital be made a county facility instead of a city owned and operated institution. It proposed that the county put up one and a half million dollars, to be raised by a bond issue, and that the city put up the hospital properties and equipment and that these funds and buildings and equipment be turned over to an independent board of trustees which would operate the hospital on a non-profit basis for the benefit of the citizens of Greenville County. It was proposed that the Board of Trustees be self-perpetuating with members from the city, members from the county, and one member from at large. These recommendations were accepted by the city, and the proposed bond issue carried in the county. Steps were immediately begun to enlarge the hospital by the addition of a new building designed to accommodate a new cooking and dining facility, new ancillary laboratories, a new administrative wing, and five new floors containing private rooms, semi-private rooms, and small wards. This building was completed in 1953 at a cost of \$5,000,000. The hospital now had 563 beds, plus the bassinets in the

new born and premature nurseries. It is not only the largest general hospital in the state, but it is also the most completely equipped.

As a part of this expansion, the Allen Bennett Memorial Hospital, with fifty beds, was built in Greer on land donated by Mr. and Mrs. B. A. Bennett. The hospital was named in honor of their son, a young surgeon who had just completed his surgical training before he entered the Naval Medical Service in World War II. He and his ship were lost in the Pacific. Although separately named, the Greer hospital is a unit of Greenville General Hospital.

All of the early troubles of the hospital were not material ones. The operation of a public hospital was a new adventure to both the governing board and the medical staff. In the fall of 1916, the entire medical staff resigned because of friction between it and the Board of Trustees. The basis of the trouble was a local outbreak of difficulties similar to those that were showing up all over the country between lay hospital management and professional staffs. The voice and the influence of the staff in hospital management has gradually assumed a greatly lessened importance everywhere. However, the change in Greenville has been accomplished in the main without serious disturbance. The "strike," as it was referred to in 1916, did not last long. Mr. Frank Barnes in the *Greenville Story* refers to "Many prominent physicians engaging in a wordy newspaper war to try to straighten out differences" in 1917.

Dr. George T. Tyler moved to Greenville in 1912. He came to do a surgical practice. In 1913, he opened a small private hospital. This was probably needed at the time, and certain it was that Dr. Tyler was happier working there than he would have been in the City Hospital, with its inadequate equipment and its stringent finances. However, his hospital ultimately served its purpose and several years before he died, Dr. Tyler moved his private surgery to the Greenville General. He closed his hospital in 1935.

A Mrs. Montgomery also operated a private hospital for a number of years. She had a rather high class clientele, which preferred the greater seclusion afforded by this small hos-

pital. Dr. T. B. Reaves and Dr. Fletcher Jordan were the principal professional supporters of this hospital during its existence.

In 1920, the Salvation Army, which for a number of years had operated a home for unwed mothers, began a project to build a general hospital in Greenville. The hospital was financed chiefly by public subscription. A very concerted appeal was made to the textile industry for assistance. The response was generous, and the hospital was built. The Emma Moss Booth Memorial Hospital was opened with 72 beds and 40 cribs. For a time, it was the place to go in Greenville when one got sick or needed an operation. Its popularity, however, did not last.

The Roman Catholic Church became interested in placing a hospital in Greenville as a part of its increasing influence in the community. It bought the Salvation Army's Emma Moss Booth Memorial Hospital and renamed it, St. Francis Hospital in 1932. It has been operated by the nursing sisterhood, The Sisters of the Poor of St. Francis. The sisters have enlarged it to 120 beds, and they continue to purchase new equipment as needed. It has proven to be a kindly place in which to be sick. Present plans are to build an entirely new and enlarged hospital, and to convert the present plant into a convalescent hospital and nursing home.

The Hopewell Tuberculosis Association operated a small cottage type hospital just beyond the city limits for more than 15 years, beginning about 1915. The county finally became willing to assume the responsibility for the treatment of its tuberculous citizens. It authorized a bond issue to build a hospital and a special yearly tax to support it. The County Tuberculosis Hospital, with 75 beds, opened in 1936.

The Shriners' Hospital for Crippled Children opened with 65 beds in 1927. It was made possible by a contribution of \$350,000 by W. W. Burgess, a wealthy citizen of Greenville. The hospital's operating expenses are paid by the Shriners, with a supplement contributed by the Duke Foundation. No patients able to pay their expenses are accepted for treatment. Only children under 14 years of age, of sound mind, and with an orthopedic

condition that can be helped are accepted. About twenty-five new patients per month were accepted prior to about 10 years ago. Since the advent of the antibiotic drugs, the number of chronic osteomyelitis cases has decreased tremendously. Also the number of children crippled by poliomyelitis is steadily decreasing. The number of new cases which can be accepted by the hospital has greatly increased. Since the hospital was built, an auditorium was added in 1943 or '44, and a large out-patient clinic building was occupied in 1957.

A negro hospital, the Working Benevolent Hospital, was operated for a number of years by that fraternal order. It rendered a valuable service to the community at a time when colored beds at the Greenville General Hospital were insufficient to meet the demand. It had a white surgical staff since there were no qualified negro surgeons in Greenville.

Dr. E. C. McClaren, a colored doctor, built and operated a very nice hospital for a time. When facilities became adequate and when negro doctors were admitted to the staff of Greenville General Hospital, Dr. McClaren closed his hospital.

The Maternity Shelter opened with 10 beds in 1932. It was sponsored by the Women's Hospital Corps. It began in a small residence in a cotton mill community. It was designed to offer hospital maternity care to multiparous women who were not eligible for free care at Greenville General and who could not pay for private care there. It has increased its facilities and its range of service and its support vastly since it began. It is now an agency of the United Fund. It receives a county appropriation for medical care of indigent mothers, and it is affiliated with Greenville General in such a way that members of the hospital intern staff each do a tour of duty at the Maternity Shelter.

Dr. J. W. Jervey operated a 15 bed hospital for the care of his own eye, ear, nose, and throat cases for many years. He opened it in 1923. It closed after his death in 1945.

This sketch should not end without mentioning the city's most unique hospital and one that is almost lost to the recollection of its citizens. Somewhere there is a reference to the

"Old Pest House" which was on the old Chick Springs Road at about the turn of the century. This, then, was the ancient forerunner of the modern and well appointed contagious ward of Greenville General Hospital, but with as great a change in the character of the patients,

no doubt, as in the facilities. The pest house was used for smallpox cases, mostly, among the poor, and Greenville has had no cases of smallpox within the writer's knowledge since his own last two cases in the nineteen hundred and twenties.

MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

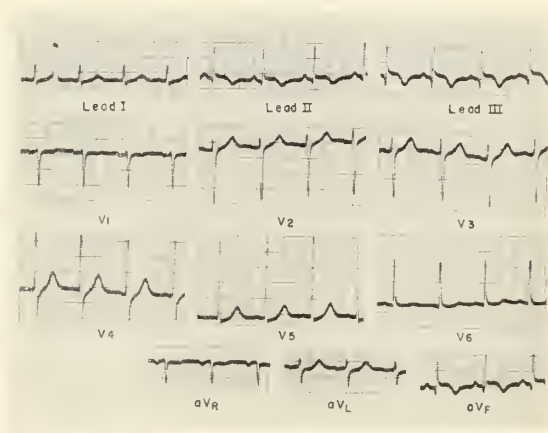
Subacute Bacterial Endocarditis

DALE GROOM, M. D.
Dept. of Medicine

Case Record—A one year illness in a young mother terminated in death at age 26. It was characterized by a low-grade fever, weight loss, weakness, transient headaches and visual disturbances, and cough with occasional hemoptysis and pleuritic pain. Early in the illness she had developed a loud mitral systolic murmur and thrill which persisted, as did a hypochromic anemia. At various times she was observed to have retinal hemorrhages, hematuria, and a small, tender petechial lesion (Osler's node) in the pad on one thumb. The clinical diagnosis of subacute bacterial endocarditis was never conclusively proven by blood cultures but intensive treatment with penicillin and streptomycin was followed by considerable improvement in the patient's condition on at least two occasions.

One of the complications which arose about midway in her illness was that of severe substernal pain radiating down the left arm. Subsequently, at the time this electrocardiogram was made, there was a transient elevation of her serum transaminase. The same pain recurred two months later but she again improved and was able to return home. Her final admission was occasioned by a sudden attack of left hemiplegia with nuchal rigidity and motor aphasia from which she died.

At autopsy her heart was dilated but weighed only 280 grams. The posterior leaflet of the mitral valve was thickened and on its free margin were small clusters of grayish nodules up to 5 mm. in size, thought to represent old vegetations. Several of the chordae tendineae of that leaflet were shortened and thickened while others were completely severed, rendering the mitral valve grossly incompetent. Evidence of old infarctions was found in the diaphragmatic wall of the left ventricle, (areas of fibrous scarring in the distribution of the posterior descending



branch of the right coronary artery), in the left occipital lobe of the brain, and in one kidney. The aorta, the coronary and the cerebral arteries showed no appreciable atherosclerosis. Immediate cause of death was a large intra-cerebral hemorrhage of the right parietal lobe.

Electrocardiogram—The Q waves in leads II, III and aVF are not of major proportions but their combination with the S-T segment elevation (1.5 mm. in aVF) and the deep inversions of T waves is strongly suggestive of an acute injury to the diaphragmatic area of the posterior wall. Reciprocal S-T depression is minimal in leads aVR and aVL but fairly definite in V₄ where the T waves became quite tall and peaked in later tracings.

There is a regular sinus rhythm (rate 98) with normal P-R and Q-T intervals. Inversion of the P wave in aVL is probably due to the semi-vertical electrical axis.

Discussion—Myocardial lesions occur with sufficient frequency in subacute bacterial endocarditis to merit mention. Aside from the hypertrophies resulting from valvular damage, the myocardium may become directly involved in the inflammatory process by simple extension and invasion or by embolization of coronary arteries with consequent infarction. Also, a diffuse myocarditis fostered by hematogenous spread

of the micro-organisms has been postulated as an explanation of the congestive heart failure which sometimes appears in bacterial endocarditis. Localized septic necrosis of the papillary muscles and myocardium as well as of the valves may rarely account for conduction abnormalities or perforation of the interventricular septum or sinus of Valsalva.

The electrocardiogram in this case is indicative of acute infarction of the posterior wall which is of course consistent with the history of chest pain and the subsequent rise in serum transaminase. The atypical feature was that the S-T segment displacements persisted for several weeks, along with the evolutionary T wave changes typical of infarction, suggesting a prolonged destructive process. One of the few signs of posterior wall infarction in the precordial leads is the reciprocal S-T depression displayed best in V₄. The small Q waves in V₆ are probably those of normal septal activation.

With the patient's known embolic involvement of other organs, an embolus to the posterior (right) coronary artery remains the most likely explanation though obstruction or embolization could not be demonstrated later at autopsy. Subacute bacterial

endocarditis is the most frequently recognized of the causes of coronary embolism which include the occasional aseptic thrombus and perhaps air embolism.

Doubtless the patient's advanced mitral insufficiency was caused mainly by the rupture of chordae tendineae during this acute illness, leaving insufficient time for development of hypertrophy of the left ventricle. Intrinsicoid deflections of R waves over the left precordium are well within normal limits and there is no indication of hypertrophy of any chamber of the heart.

Antibiotics have so altered the pathology of subacute bacterial endocarditis that one seldom sees the friable septic vegetations on which the autopsy diagnosis was classically based. Obviously the clinical picture and prognosis have changed, also. But a major gap remains between bacteriological cure and recovery of the patient, many of these patients still succumbing to relapses or complications of the disease.

Acknowledgement: I am indebted to Dr. Edward McKee of the Department of Pathology for help on the autopsy aspects of this case.

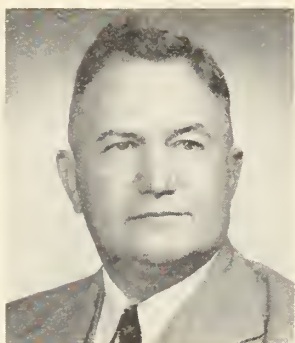
Valsalva maneuver as a diagnostic aid. (J.A.M.A. 170:787-791, June 13, 1959)

Two hundred and five selected office patients were given careful examinations following which a modification of the Valsalva maneuver was done. This consisted of having the patients strain against 40 mm. of pressure using an Asepto syringe connected to a Tycos manometer gauge. The straining is maintained for ten seconds and blood pressure is determined before, during, and after the period of straining. Evidence of congestive heart failure is manifested by a failure to develop the normal fall during the period of straining and the normal rise after straining. Similar findings are noted with some obstructive valvular lesions such as mitral and aortic stenosis. Emphysema gave a diametrically opposite response. The test was felt to be valuable and as it was quite simple and easy to do, should be a part of the armamentarium of all physicians.

The 1955 model of patient is a different individual than the 1935 model. The later model is a better educated person, and much better informed about medical matters because of medical columnists, magazine articles, books, radio, and television. If he watches "Medic" on television he may even know how to

operate. The gripes twenty years ago were that the other fellow did not cure him or at least not fast enough. The gripes of today are different. He tells you that the other fellow did not take any interest in him, was completely impersonal, hurried him through, told him there was nothing wrong with him, did not explain things to him or used medical jargon, and charged him too much. In brief, he looks upon us as scientists and mechanics and not as physicians in the true sense of the word. He would like to have sympathy and understanding in addition to the magic medicines and spectacular techniques; in other words, to be considered as more important than his disease. Dr. Joseph Collins, who had a great deal of experience as a patient, has written, "It is only human nature for the man who deals daily with bodily deformities and mental shortcomings to grow superior to his world. If he happens to be a big vigorous man himself, this sense of personal fitness easily breeds the arrogance, bored tolerance, facile condescension, and autocratic dogmatism with which physicians are often charged."

(From "Public Relations and the Patient" by William J. Butler, MD. Tucson, Arizona. Printed in *The Michigan State Medical Society Journal*, December, 1958)



PRESIDENT'S PAGE

THE AGED

There are over 15 million people in the U.S.A. who are 65 years and above. Sixty-five is the retirement age, though it seldom applies to the physician, as you can count on your hand the number of medical doctors in South Carolina who have retired, and I doubt they would equal the number of fingers on both hands. Is this a good or bad sign? I would say it is excellent, for as long as one is occupied and mentally alert he is happy.

There are three classes of the oldster with whom we come in contact:

1. The sick oldster
2. The frail or fragile oldster who without good attention would become sick, and
3. The well oldster, who, if guided by a positive health program should be able to solve most of his own problems.

The doctor realizes from his experience that the stigma and diseases usually associated with the aging are due to the impact of stress and environment.

Hardening of the arteries is no worse than softening of the arteries with the loss of the will to live.

Loneliness, rejection, loss or lack of interest, neighborless, and no occupation will result in emptiness for the aged, meaning no desire to live. We must prevent these manifestations.

What are we doing about the aged? Geriatrics or gerontology is certainly a responsibility of the physician, since we are the ones who have caused the increase in prolongation of life. The reduction in childhood mortality and better care for the premature and infant is the beginning of the older citizens. Better and purer foods have an important role in adding to the span of life. Chemotherapy and antibiotics contribute their part.

There are no diseases specific to the aged, but we have diseases among the aged. For instance, there have been 98 arteriosclerotic heart diseases, including coronary, in children under five years of age, and these we find in every age bracket thereafter.

Voluntary health insurance is the method the A.M.A. sponsors in helping to take care of the elder citizens. Thirty-nine per cent in the years 65 and over now carry health insurance. The breakdown in this group is found in the bulletin, "Progress in Health Services - Health Information Foundation", (8: Jan. 1959) (420 Lexington Ave., N. Y. 17, N. Y.)

GOALS OF THE A.M.A. ON AGING

- (1) Adequate medical care at the lowest practical cost for those who are ill.
- (2) Promotion of better understanding and wider use of restorative services on behalf of those who are disabled.
- (3) Encouragement of activities, both group and individual, for the prevention of illness among all older persons, and
- (4) The promotion of longrange positive health programs which will increase the over-all capacities of persons to live active, meaningful lives in their later years.

Environment is a big factor in dealing with the aged. Chronically sick older people can be treated at home if they desire to remain there with adequate nursing, physiotherapy, occupational therapy and proper medical guidance. Determine where the interest of the individual lies and apply the therapy games, knitting, sewing, religion, handicraft, birdwatching, radio, television, reading, etc. One should certainly visit St. Petersburg, Florida, to see these old timers play baseball, bowl, golf, swim, croquet, fish, shuffleboard, walk and dance. You would realize they have a useful place in this universe. A wrinkled skin need not be a wrinkled mind, heart and soul.

William Weston, Jr.
President

Editorials

PROGRAM FOR THE MAY MEETING

Winter has come, spring will not be far behind, and the Annual Meeting of the Association at Myrtle Beach in May will be upon us.

Perhaps now is a good time to reflect a little bit on the programs at the Annual Meeting. Year after year a hard working program committee produces for our members an array of visiting speakers of eminence, ability, and sometimes of eloquence. Year after year these speakers face the dismal prospect of delivering their addresses to a corporal's guard of members who have resisted the temptations of the fleshpots which are to be had at every meeting. It is a discouraging experience for a noted physician to find such a welcome when he has traveled far and spent much time without any material recompense. It would seem to be good manners at least to have our members listen attentively and in number, even if the subject of the particular speaker may not be of too direct interest to them.

One wonders what the secret is for providing a good attendance. Frequently when a speaker is a bit on the fringe of some medical borderland, he draws a much bigger audience than does the man who is established, experienced, and even famous. It is curious to wonder what brings most of our members to the meetings. Periodically one hears complaints that there is not enough post graduate instruction and that something must be done about it, but when such instruction is provided, the indignation of the complainer has subsided, and he is not to be found.

We go back to Myrtle Beach this year, where the perilous pleasures of the beach may be too distracting for the scientific inquiring mind. It will be a pity to have the kind of neglect that has been given to speakers in the past passed on to the outstanding men who will appear this year. The current program committee has worked hard to secure good talent. Among the speakers will be Dr. George Anderson of Providence, Rhode Island and Dr. Robert A. Cosgrove of Jersey City. Both of

these will give addresses and will also participate in the panel on perinatal problems. Similarly Dr. Edward Krementz of New Orleans and Dr. A. R. Curreri of Madison, Wisconsin will speak and will be active in a panel on Chemo-Therapy and Hormonal Therapy of Cancer. On the interesting subject of geriatrics, Dr. E. V. Allen of the Mayo Clinic and Dr. A. C. McCarty of Louisville will contribute their knowledge, as will Dr. Kenneth Appel of Philadelphia, a really brilliant speaker and an exponent of middle of the road psychiatry. His paper will be on "Basic Psychotherapy". Dr. Allen will present a paper on "The Natural History of Arteriosclerosis".

A panel discussion on cardiovascular disease will be brightened by Dr. Bruce Logue of Atlanta and Dr. Harry Muller of Charlottesville. A number of our own members will participate in these panels and act as moderators in most cases.

A new departure this year is a group presentation from our own members. The ophthalmologists are getting together a single presentation on "Glaucoma in General Practice". Dr. Howard Stokes is responsible for the production. It is hoped that if this presentation is well accepted other specialty groups may undertake a similar sort of thing for future programs.

These distinguished visitors and members will undoubtedly offer an excellent program. It deserves an excellence of attendance.

STATE ASSOCIATION ANNOUNCES A NEW INSURANCE PROGRAM OFFERING TAX ADVANTAGES

The Commissioner of Internal Revenue and the courts have ruled that under the 1954 Internal Revenue Code, form No. 162, premiums paid for a business overhead expense insurance policy are tax deductible. The benefits payable under the policy are to cover monthly expenses actually incurred in the operation of your office, thus, making this deduction possible.

The State Association's insurance committee, headed by Dr. Clay Evatt, reviewed several insurance

programs, and recommended to the Council that the Association sponsor this business overhead expense plan. This plan is now being submitted to the membership for their individual consideration.

The business overhead expense policy is a very inexpensive means of maintaining your office during a period of disability, as the premium rates are decidedly less than those charged for disability income insurance. The policy will reimburse you up to 75% of your normal office operating expense, and in the case of a partnership, the company will pay the insured's proportion of such expense.

The insurance program will be administered by The General Agency, 11 State Street, Charleston, South Carolina, an independent insurance firm,

specializing in association group coverages. It will be their responsibility to install the group program, handle all general correspondence, billings, claims, etc. The insurance program is being underwritten by one of America's leading insurance companies, The Continental Casualty Company.

Each member of the Association will receive, by mail, a brochure explaining the insurance program, and a representative of The General Agency will personally contact him to discuss the details of the plan. You are urged to give this your consideration, for if 50% of our members apply during the initial enrollment period, the company guarantees to issue a policy to each applicant regardless of his prior medical history.

COLLEGE POLICY TOWARD COUNTY INDIGENT PATIENTS TO DETERMINE HOSPITAL STANDARDS GENERALLY AVAILABLE TO CHARLESTON COMMUNITY

WM. H. PRIOLEAU, M. D.
Charleston, S. C.

Decisions to be made within the next few months concerning the care of Charleston County indigent patients will determine the scope and standards of hospital facilities to be generally available to the community for the foreseeable future. For many years the Charleston County indigent patients have been hospitalized at the Roper Hospital and attended by the faculty of the Medical College. This arrangement has enabled Roper Hospital to serve the community as a highly accredited hospital with well-developed departments in the specialties. It has also made available to the Medical College a large group of patients of great value in teaching medical students and the training of interns and residents.

This arrangement had to be discontinued several months ago when the Roper Main Building, in which these patients were housed, had to be closed as it failed to meet the requirements of the Joint Commission on Accreditation of Hospitals. The Medical College Hospital agreed to accept these patients as an emergency measure so as to prevent a situation which would have had serious consequences from the standpoint of the College and the community. At the same time it stipulated that it would not assume responsibility for their care beyond January, 1961 unless County Council by that time had made permanent plans for their hospitalization. County Council has engaged the services of a team of medical consultants to make a survey of the hospital needs of the community with particular reference to the care of the indigent patients and the maintenance of an Emergency Room.

Indigent patients of sufficient number are of great value in the basic functioning of a general hospital. This type of patient is important in a teaching pro-

gram and is essential for residency training in the various specialties. Charleston County indigent patients are supported by local taxes. They should be hospitalized in such a manner that they can be used for educational and training programs—which would enhance the scope and standards of hospital facilities generally available to the community. Any new construction by the county should be in proximity to Roper so that a close working relationship can be established between the two institutions. Effort should be made to retain the desirable features of the recent arrangement which served to the benefit of the community over many years, and to remove the more controversial features, particularly those dealing with cost allocation. Such an arrangement would enable Roper Hospital to continue to provide the community with the services of an accredited hospital with well-developed departments in the various specialties. It would also permit Roper to continue to be of value to the Medical College in its educational program by providing a block of indigent patients under conditions satisfactory for teaching and resident training.

The need for a well-equipped and well-staffed community hospital is becoming more apparent every day. While the Medical College Hospital is a valuable asset to the community in making available certain skills and facilities on a referral basis, it was constructed to serve the state and it cannot be expected to relieve the community of the necessity of providing hospital facilities to meet its normal requirements. Physicians on the voluntary faculty who are in private practice are now finding it difficult to secure admission of their patients to the Medical College Hospital. The facilities of the Medical College Hospital will become less available to the residents of the community as it

becomes better established as a referral hospital on a state-wide basis.

The Medical College would render an invaluable service to the community if it would take an unequivocal stand that the care of Charleston County indigent patients does not come within the province of the state hospital, except as an emergency measure. That there is needed a statement by the Medical College concerning its present policy regarding the care of Charleston County indigent patients is clearly indicated by the proceedings of the Medical Society of South Carolina and reports of conferences by representatives of the County Council, the Medical College and the Roper Hospital. A statement of

recognition by the Medical College that the care of Charleston County indigent patients is within the province of the community hospital would be of particular value if it were made in time to be taken into consideration by the consultants engaged by County Council to make a survey of the hospital needs of the community. It would pave the way for a suitable arrangement between County Council and Roper Hospital for the care of Charleston County indigent patients in such a manner as to raise the scope and standards of hospital facilities generally available to the community. It would enable Roper to continue a close affiliation with the Medical College and take an important part in its educational program.



BLUE CROSS . . . BLUE SHIELD



BEDS—NOT ENOUGH? TOO MANY?

Richard J. Aekart, M. D.

"The public should exercise better control over its capital investment in hospitals. . . . The quality of care is, of course, in the hands of physicians and the professions concerned with hospitalization. . . . But the public is entitled to control the expenditures. . . . Any community should view with alarm the expansion of hospital facilities except in response to a recognized immediate or future need"¹ Published in the year 1930, the foregoing statement referred to widespread activity in hospital construction during the preceding decade, when community coordination was not taken seriously. Times have changed—hospital planning now is, or indeed should be, a primary concern not only of local hospital bodies but of authorities and organizations which are in a position to effectuate state-wide coordination—The Medical Society of Virginia, for example.

Because health care is such a fast-changing complex of activity in America, with different developments pointing in different directions, the future of hospitals and of medical practice cannot be foreseen. We cannot rest assured that the public will continue to pay whatever is required to maintain health care on a voluntary basis. On the other hand, we need not agree with those who say that we will all be taken into socialized medicine in the next few years. It depends on what doctors, hospital people, and others in the health field do in the meantime. The doctors of each state, individually and—perhaps more effectively—through their medical societies can influence the future of health care by influencing the future development of hospital facilities.

Not too many years ago the hospitals of Virginia did a remarkable job of meeting needs for hospital-care despite what were then properly recognized as acute bed-shortages. But many beds have been con-

structed in the interim, and it might be that the era of shortages has come to an end. There is reason to believe that it has. As a matter of fact, there is a possibility that Virginia will have a costly surplus of beds if too many of those already in sight are put into service too soon; careful state-wide planning is needed if we are not to go from one extreme to the other.

There is a plethora of evidence that the rising costs of hospitalization are making more and more people believe—rightfully or wrongfully—that those costs should be placed under other than voluntary regulation. Because of the constant over-head expenses involved, each and every hospital bed beyond absolute need—be it unused or misused—unnecessarily adds about \$7,500 to Virginia's total annual hospital bill. Accordingly, a major factor in holding down future hospital costs will consist of not building more hospital facilities than are actually needed.

Many of the existing hospitals in Virginia draw their patients from a wide area. Therefore, bed additions by one hospital may reduce the patient load of a number of other hospitals throughout the area, leaving these other hospitals with a Hobson's choice—to accept the expense of supporting beds in idleness, or to accept as bed-patients those whose condition does not require or justify bed-care. In either case the over-all hospital bill for Virginians increases.

Not only hospital beds but also hospital services should fit into the state-wide, coordinated health-care scheme. The addition of expensive hospital services when such services are available in adequate measure in neighboring hospitals is just as wasteful of the health-care dollars of Virginians as is the addition of unnecessary beds.

How many existing beds are—or may be—unnecessary? The fact that the existing beds are kept in use is no criteria on which to base an answer, nor is the fact

that a given hospital may be unable to admit all comers on a given day. An apparent need for more beds might well be satisfied were the hospitals to provide proper facilities for private ambulatory patients; conversely, construction of such facilities might well prove that many existing beds are unnecessary. All too few hospitals in Virginia offer proper facilities to which physicians can refer their private ambulatory patients for x-ray examinations, laboratory tests, and diagnostic work-ups. These private vertical patients should, of course, be received in adequate waiting rooms on an appointment basis, and the doctor should be provided with suitable space for consultations. We must discard the anachronistic idea that out-patient facilities are for indigent patients.

The various health-care activities of our hospitals need to be orchestrated not only in local communities but also on a regional and on a state-wide basis. Virginia must, of course, have enough hospital beds, but care should be taken to avoid the needless expense of too many. In its attempt to control its capital investment in hospitals, the Virginia public leans heavily upon the advice of Virginia doctors; accordingly, through our various organizations and societies, we should subject existing hospital facilities and services to a thorough-going and objective analysis in order to give truly astute advice to the public we are dedicated to serve.

If we consider that socialized medicine is not a good system, and is not inevitable, then we are committed to positive programs of study of the shortcomings of our present system, and positive programs toward the alleviation of these shortcomings. Because of the number of dollars involved, and because of the public's obvious concern, perhaps the best place to start is with our hospital facilities and services.

1. Rorem, C. Rufus. *The Public's Investment in Hospitals*. University of Chicago Press, 1930, p. 216.

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NEWS

COLUMBIA MEDICAL SOCIETY

The Columbia Medical Society held its Annual Meeting for the Election of Officers on Monday, December 14th, 1959. Dr. W. A. Hart was named President for 1960. The Society for the first time elected a President-Elect, Dr. Weston C. Cook, who will become President in 1961. Other officers elected were: Dr. John H. Young, Vice-President; Dr. C. R. Sloan, Secretary; Dr. Waitus O. Tanner, Treasurer; Dr. R. P. Watson, Editor of *The Recorder*.

Dr. J. William Pitts was elected to membership on the Public Relations Committee, and Dr. Lewis Pitts was elected to membership on the Board of Censors. The following were elected to serve on the Executive Committee: Dr. C. T. Weston, Dr. John Holler, Dr. Kirby D. Shealy, and Dr. Richard J. Kahaly.

Drs. M. W. Cheatham and H. F. Hall were elected

Delegates to the South Carolina Medical Association. Alternate Delegates elected were: Dr. C. F. Crews, Dr. R. G. Latimer, Dr. C. K. Lindler, and Dr. H. A. Skinner.

The guest speaker for the February Scientific Meeting of the Columbia Medical Society was Dr. Edward H. Ryncarson, Mayo Clinic, Rochester, Minnesota. Dr. Ryncarson spoke on the subject "True Hyperinsulinism versus Functional Hypoglycemia".

Dr. George W. Brunson of Columbia also spoke at this meeting, his subject being "Pitfalls of Radiology".

DR. COCHRAN NAMED CHAIRMAN FOR HEALTH CARE OF THE AGED

An organizational meeting of the State Joint Council for Health Care of the Aged at Columbia on December 9 elected Dr. William N. Cochran of Spartanburg as its first chairman.

Initiated by the South Carolina Medical Association, the Council is composed of representatives from the medical group, the South Carolina Dental Association, the South Carolina Hospital Association and the South Carolina Association of Nursing Homes.

The council's general aim is the research and solution of medical economic and social problems facing the state's aged population.

During an hour-long session at the Hotel Columbia, the Council named Dr. Neill W. Macaulay of Columbia vice chairman and elected Miss Grace S. Southerland of Myrtle Beach secretary.

Dr. Cochran represents the Medical Association, Dr. Macaulay the Dental Association and Miss Southerland the Nursing Home Association.

A steering committee was appointed to map out a specific program for the Council which will work in conjunction with the National Joint Council. Members named were:

Dr. R. L. Crawford of Lancaster, immediate past president of the South Carolina Medical Association; M. L. Meadors of Florence, executive secretary of the Medical Association; Miss Esther Touchberry of Lancaster, representing the Hospital Association; Dr. J. I. Waring of Charleston, editor of the *Journal of the South Carolina Medical Association*, and Miss Southerland.

Earlier, Dr. G. F. McDaniel, director of the Division of Disease Prevention of the State Board of Health, said persons over 65 years of age represent about 7 per cent of the population of South Carolina.

He added that the board staff is preparing other statistical material aimed at aiding in the campaign to alleviate problems created by an increasing aged population.

Dr. McDaniel said the board is conducting pilot studies in four counties on home nursing programs for aged persons who are being cared for by their families.

"I think we're going to find," he added, "that this may be a great help in one area of this problem."

Dr. Cochran noted that a Legislative-Governor's

Committee headed by Rep. Martha Fitzgerald of Columbia is delving into the same problem and suggested that the Council offer its full aid and cooperation to the legislative group.

BIDS SOUGHT

The Board of Trustees of the Laurens County Hospital has called for sealed bids on the construction and equipping of a \$360,000 addition.

Board Chairman Marcus S. Boyd said bids were to be opened January 6 in the office of the hospital administrator.

Under consideration are a 16-bed nursing unit, surgical x-ray suites, and a boiler room. About half of the cost will be met by federal funds.

WOODRUFF GETS NEW PHYSICIAN

Dr. Oliver E. Gilliland, who has practiced medicine at Enoree for the past two and a half years, will move his office to Woodruff, he announced.

He is a graduate of Louisiana State University and the Medical School of LSU.

His office will be in the Woodruff Building on S. Main St.

MEDICAL COLLEGE GETS \$108,000

The Medical College of South Carolina and the Medical College Hospital are recipients of a \$108,000 grant to assist in a program to train physicians in the field of neurology.

The grant was made by the National Institute of Neurological Diseases and Blindness.

The renewal of support for three more years starting in May, 1960, assures continuation of the program. The program was begun in 1956.

DR. CLAYTOR JOINS STAFF AT VA HOSPITAL

The appointment of Dr. Philip P. Claytor as a staff physician at the Columbia Veterans Administration Hospital was announced by the management.

Dr. Claytor, a native of South Carolina, received his M. D. degree from the Medical College of South Carolina in 1955. He served a 12-month rotating internship at the Medical Center Hospital in Charleston.

He served in the Air Force during the Korean Conflict.

Prior to his appointment, he was engaged in private practice in York for approximately two and one half years.

Gordon T. Wannamaker, M. D., diplomate of American Board of Neurological Surgery, announces the opening of his office in the practice of neurosurgery at 134 Rutledge Avenue, Charleston.

Dr. John L. Valley of Pickens was to retire on the first of the year after devoting 52 years and seven months of his life to the service of the citizens of Pickens as a physician.

Loved by all in the county and recognized often for his devotion and service, Dr. Valley will begin his 76th year of life by traveling throughout the United States visiting friends and relatives.

Dr. Valley was born January 23, 1883, in Michigan and completed his schooling in Tennessee, beginning the practice of medicine on May 28, 1907. In March of 1908, he came to Pickens and has been there ever since. June 1, 1949, was designated as "Dr. Valley Day" in Pickens and a handsome plaque inscribed "in honor of a great humanitarian, for his unselfish service with appreciation, love and devotion from his friends." Dr. Valley stopped delivering babies over a year ago saying it was too much night work for an old man but he estimates he has delivered approximately 6,700 children during his practice. He and his son, Dr. Tom Valley, have shared an office in recent years.

Long active as a Mason, Dr. Valley was potentate of Hejaz Temple when the Shrine Bowl game was inaugurated in Charlotte, N. C., in 1937. The first year's gate, donated then as now to the Greenville Crippled Children's Hospital was \$19,000.

Dr. Valley was a member of the Pickens Town Council for 32 years and helped inaugurate the Board of Health. He was also head of the Red Cross for a number of years.

Carter P. Maguire, M. D. announces the removal of his office to 134-A Rutledge Avenue, Charleston, S. C. Plastic and Reconstructive Surgery.

S. C. MEDICAL EXAMINERS LICENSE 21 APPLICANTS

The South Carolina State Board of Medical Examiners licensed 21 applicants by endorsement at a meeting in December in Columbia. Dr. H. E. Jervey, Jr., secretary, has announced.

Those approved by the board include Dr. M. Janet Alexander of Erskine College. A graduate of the Woman's Medical College of Pennsylvania in 1917, she was a medical missionary in Pakistan for a number of years.

Dr. Jean D. Bayless of Ridgeland, who will do general practice. Doctor Bayless is a graduate of the Rochester School of Medicine and Dent., 1957.

Dr. Clark S. Collins at Greenville, Columbia University's College of P and S, 1951. He took a residency in Otolaryngology at Mass. Eye and Ear Infirmary in Boston.

Dr. Hiram B. Curry at Charleston, Medical College of S. C., 1950. Doctor Curry is a resident in neurology at the Medical College of South Carolina.

Dr. John T. Daves at Columbia, graduate of University of Maryland School of Medicine, 1917. Doctor Daves is with the Veterans Hospital.

Dr. Thomas E. Edwards at Columbia, graduate of University of Tennessee, 1946. He will finish a residency in orthopedics January 1 at Columbia Hospital.

Dr. George W. Galloway, Jr., at Columbia, graduate of University of Tennessee, 1958, formerly licensed

in Mississippi, and will do general practice at 3201 Millwood Avenue.

Dr. Joseph E. Greene of Greer, graduate of Medical College of Georgia, 1949, and has a general practice.

Dr. Byron R. Lewin of Crescent Beach, graduate of McGill University, 1934, and has been practicing medicine and surgery in Claremont, N. H. for the past 22 years.

Dr. Richard B. Maxwell, Jr., at Myrtle Beach, graduate of Cornell University, 1945. He took a residency in medicine at New York Hospital.

Dr. Harry C. Oard of Charleston, graduate of Yale University School of Medicine, 1928. He is district medical officer for Sixth Naval District.

Dr. Kenneth N. Owens of Aiken, a graduate of the University of Colorado School of Medicine, 1948. He took a residency in Obstetrics-Gynecology, and recently was discharged from the army, having served in the Medical Corps since 1948.

Dr. William R. Purcell of Charleston, a graduate of the University of N. C. School of Medicine, 1956. He is taking a residency in pediatrics at the Medical College in Charleston.

Dr. Ronald L. Redfield of Oil City, Pa., a graduate of Jefferson Medical College, 1934. He took a residency in surgery in Buffalo, N. Y., and will locate in South Carolina.

Dr. Robert N. Schneiderman of Beaufort, a graduate of Northwestern University, 1955. He took a residency in dermatology and presently is at the U. S. N. Hospital in Beaufort.

Dr. Claude A. Smith of Columbia, a graduate of Jefferson Medical College, 1953. He recently finished a residency in radiology at Duke and is now at Columbia Hospital.

Dr. Suzanne H. Sword of Beaufort, a graduate of N. Y. Medical College, 1956, who will do general practice in Beaufort.

Dr. Harry D. Tripp of Columbia, a graduate of Northwestern University, 1930, now on the State Hospital staff.

Dr. Joseph T. Wearn of Cleveland, Ohio, a graduate of Harvard Medical School, 1917, now dean of Western Reserve University School of Medicine in Cleveland. He plans to live in Yemassee when he retires.

Dr. Theodore S. Wedde of Rock Hill, graduate of College of Med. Evang., 1937. He took a residency in pathology and now is at York County Hospital.

Dr. William F. Young of Sumter, graduate of the University of Pennsylvania School of Medicine, 1954. He recently finished a residency in pediatrics at Childrens Hospital of Philadelphia.

Successful candidates of 23 applicants for licensure by written examination, will be announced later, Doctor Jervey said.

Lynn Derrick, M. D. announces the opening of his office for the practice of General Medicine at 1822 Washington St., Columbia.

DR. WYMAN HEAD OF DOCTORS

Dr. Joel Wyman, Anderson skin specialist, took office January 1, as president of the Anderson County Medical Society. He succeeds Dr. William Lummus.

Others elected include Dr. Charles Browne, vice president; Dr. Thomas A. Collins, secretary; and Dr. J. W. Jackson who was re-elected treasurer.

Retiring officers include Dr. Jimmy Young, vice president; and Dr. Robert G. Thompson, secretary.

DR. JOHN WORKMAN TO STUDY ANESTHESIOLOGY

Dr. John Anderson Workman, native of Woodruff, will enter Duke University around the first of the year to study anesthesiology.

Dr. Workman has been associated with Dr. B. J. Workman, Sr. and Dr. B. J. Workman, Jr. at Workman Clinic since 1953.

He graduated from Wofford College in 1940 and the Medical College of South Carolina in Charleston.

DR. LIPPETT IS AREA CHIEF OF SURGERY

Dr. Karl M. Lippert, chief of surgery of the Veterans Administration Hospital in Columbia since July 1946, has been named Area Chief of Surgery for Veterans Administration Area 7.

In the new post, Doctor Lippert will be chief of surgery for the Veterans Administration in Ohio, Indiana, Kentucky, Michigan and Illinois. He will take over the new position, with headquarters at Columbus, Ohio, Jan. 23.

Doctor Lippert began his private practice in Lancaster in 1938, and in 1942 became chief of staff of the Marion Sims Hospital in Lancaster.

His Army service began in 1942 as chief of surgery, 60th Station Hospital, Mediterranean theater, and continued until 1946, at which time he joined the Veterans Hospital here. He rose from Captain to Colonel in the Army, and has received the Bronze Star.

Doctor Lippert is a graduate of the Liberal Arts and Medical College of the University of Cincinnati, having been awarded the A. B. degree in 1928, the M. B. in 1932, and M. D. in 1933. He interned at Cincinnati General Hospital. In 1934 he was assistant resident pathologist at Vanderbilt University and from 1934 to 1938, resident in surgery, at the Medical College of Virginia.

He is a member of the First Presbyterian Church, a senior active member of the Five Points Rotary Club, a member of the Executives Club and a Mason. Doctor Lippert is listed in Who's Who In The South 1959. He has had 28 articles printed in medical publications with three to appear.

He is an affiliate of the following medical organizations: Fellow American College of Surgeons, Fellow International College of Surgeons, Diplomate American Board of Surgery, Diplomate American Board of Thoracic Surgery, Fellow American Association Traumatic Surgeons, Fellow American Association of

Geriatrics Service Fellow, American Medical Association, South Carolina Medical Association, Columbia Medical Society, member of past president, South Carolina Surgical Society, listed in directory of Medical Specialists, consultant in surgery to South Carolina State Hospital and visiting staff Columbia Hospital.

Vacancy, Whitten Village, for qualified medical doctor. Preferably young man. Experience pediatrics or psychiatry important but do not supercede good background, and not required. Early promotion to Superintendent if desired and acceptable to Board of Trustees. Salary and other benefits to be made satisfactory. Three good assistants now serving. New, well equipped hospital on premises available one year hence. Communicate with Superintendent, Whitten Village, Clinton, S. C.

DR. CARDWELL REAPPOINTED TO VA HOSPITAL POST

Dr. Edward S. Cardwell has been reappointed chief of laboratory service at the Columbia Veterans Administration Hospital according to Thomas B. May, hospital manager.

Dr. Cardwell served the hospital as chief pathologist from May 1949 until February 1956.

Dr. Cardwell received his M. D. degree at the Medical College of South Carolina in 1934, served an internship at Columbia Hospital in 1935 and as pathology resident at the Medical College. He was in general practice in Columbia from July, 1936, to July, 1937, and taught in various medical schools from 1937 to 1941.

He served in the armed forces from July 12, 1941, until March 6, 1946, and was assistant professor of pathology at the University of Georgia Medical School from January 1, 1947, to July 1, 1948. He was pathologist in Greenville from July 1, 1948, to May 17, 1949.

Dr. Cardwell is a member of the American Board of Pathology, the Columbia Medical Society, the South Carolina Medical Association, the American Medical Association and the South Carolina Society of Pathologists.

DOCTORS OPEN OFFICE IN CENTRAL

Dr. E. G. Shealy and Dr. G. W. Smith, who have an office in Easley, have also opened an office in Central.

Both of these young doctors have recently finished services with the United States Army.

Dr. Shealy is a native of Batesburg, and attended Presbyterian College and the Medical College of South Carolina.

Dr. Smith is from Pickens County. He is also a graduate of the Medical College.

DR. SHEPHERD ACCEPTS POST

Dr. Fred P. Shepherd of Aiken, plant physician for the Du Pont Company at the Savannah River Plant, has accepted a post as medical director of the Louisville DuPont Works in Louisville, Ky.

S. C. NATIVE NAMED U. S. DOCTOR OF '59

Dr. Chesley M. Martin, a South Carolinian who devoted most of his 70 years to the little Oklahoma town of Elgin, is the American Medical Association "Family Doctor of the Year."

Dr. Martin, who was born on a plantation near Anderson, S. C., has 44 years of practice behind him. He still works a 72-hour week which includes helping 25 Comanche Indian families as their "medicine man." He has delivered 2,500 babies in his career.

The AMA says he "typifies the thousands of general practitioners who have dedicated their lives to the practice of medicine and who have given exceptional service to their communities."

Eleven years ago, Dr. William L. (Buck) Pressly, a native of Due West, S. C., was named "Family Doctor of the Year" of 1948. His father was a professor of Greek and Latin at Erskine College. The son played professional baseball to raise money to finance his medical education at Emory University.

MEDICAL COLLEGE ALUMNI FORM AID FOUNDATION

A Medical College of South Carolina Foundation was formed recently at a meeting of alumni of the college in Atlanta.

An announcement by Dr. Jack C. Norris, secretary of the College's National Alumni Association, said the purpose of the foundation will be to promote the interest of the Medical College in medical research, education and public service and to receive contributions for that purpose.

Dr. Kenneth M. Lynch, president of the Medical College, made the principal address at the annual dinner and was presented with the Diamond Jubilee Gold Key of the Southern Medical Association.

Hosts for the meeting, held at the Academy of Medicine in Atlanta, were Dr. Jack C. Norris, Dr. Major Fowler, Dr. Samuel Norwood and Dr. Calvin Stewart.

The more than 100 alumnus and friends of the Medical College in attendance became charter members of the new foundation.

The South Carolina Medical Association urges you to

FIGHT FOR AND

Send a handwritten letter to your congressmen and any others who may have a voice or a vote.

NEUROLOGY STUDY GRANT IS RECEIVED

The National Institute of Neurological Diseases and Blindness has awarded a grant of \$108,000 to the Division of Neurology of the Medical College and Medical College Hospital.

The purpose of the grant, to extend over a three-year period, is to assist in the support of a program to train physicians for teaching and research careers in the specialty of neurology.

The training program, under the direction of Dr. Rhett Talbert, assistant professor of neurology at the Medical College, was begun in 1956 and has received support from the National Institutes of Health. The renewal of support beginning in May, 1960 assures continuation of the program.

In addition to supervised experience in clinical aspects of neurological diseases, the program provides advanced training in the basic science aspects of anatomy, physiology and pathology of diseases of the nervous system. At least three years of training after completion of internship are required to qualify the physician for certification in this specialty.

Four young physicians, all graduates of the University of North Carolina School of Medicine, will open practice in Hartsville during the coming year.

The four doctors will encompass the fields of internal medicine, pediatrics, obstetrics and gynecology.

Three of them will complete their residency requirements at the North Carolina Memorial Hospital in Chapel Hill, N. C. next June 30. The fourth will finish his service with the Navy Medical Corps next November.

All will be eligible for certification by the American boards of their respective specialties. The physicians are as follows:

Dr. Edward S. Williams, internal medicine. Dr. Williams was born in Greenville, N. C. and attended the public schools there. He is a graduate of University of North Carolina and the UNC School of Medicine. He is now completing his residency at North Carolina Memorial Hospital.

Dr. Griggs C. Dickson, pediatrics. Dr. Dickson was born in Garner, N. C., where he attended the public schools. He is a graduate of the University of North Carolina and of the UNC School of Medicine. Dr. Dickson is currently completing his residency at North Carolina Memorial Hospital.

Dr. Charles H. Owens, obstetrics and gynecology. Born in Avondale, N. C., Dr. Owens attended the public schools in Caroleen, N. C. He is a graduate of Davidson College and of the University of North Carolina School of Medicine. He is now completing his residency at North Carolina Memorial Hospital.

Dr. J. C. Parke, Jr., pediatrics. Dr. Parke was reared in Conway, N. C., where he attended the public schools. He is a graduate of University of North Carolina and of the UNC School of Medicine. Dr. Parke is currently serving as a lieutenant in the Navy Medical Corps.

Since the death of Dr. C. M. Scott last June, Hartsville has had only eleven doctors to serve a population estimated at 30,000 to 40,000 in the city's trading area. The trustees and the medical staff of Byerly Hospital have been engaged for some time in an effort to bring more doctors to Hartsville to serve its growing population. Mr. Sory said.

DR. E. FINGER PRESIDENT-NOMINATE

Dr. Elliott Finger was nominated president of the Pee Dee Medical Society at the meeting held recently at the Little Pee Dee Lodge. With Dr. Thomas B. Clark, president, presiding, the following doctors were elected to offices in the society:

Dr. Randy Elvington of Nichols, president-elect; Dr. Ed. Rice of Mullins, vice president; Dr. D. G. Kitchens of Marion, secretary-treasurer; Dr. S. O. Cantey, Jr., of Marion, delegate to the State Convention; Dr. H. S. Gilmore of Nichols, alternate.

Dr. A. S. Pearson, physician of 340 E. Haynes St., was named Spartanburg County "Doctor of the Year" at the annual meeting of the Spartanburg County

Medical Society Monday at the Spartanburg Country Club.

Dr. Allen B. Warren, in presenting the award, cited Dr. Pearson as a "fine physician, a community leader and an example for others in the profession to follow."

Dr. Pearson is a native of Woodruff, a son of the late Cora Wofford Pearson and Basco Pearson. He is a graduate of the Medical College of South Carolina and served his internship at Roper Hospital in Charleston and the Spartanburg hospitals. He has been practicing in Woodruff since 1928.

Dr. Pearson has held every office in the State Foxhunters' Association and is now a vice president of the National Foxhunters' Association.

He is a member and former president of the Woodruff Rotary Club and has been active in the Chamber of Commerce and the First Baptist Church. He is associated with Dr. Lewis Barnett, Jr. at the Medical Center on E. Georgia Street.

OFFICERS NAMED

Dr. J. I. Converse is the new president of the Greenville County Medical Society. Other officers elected Tuesday are president-elect, Dr. Horace Whitworth; vice president, Dr. L. H. Taylor; secretary, Dr. John C. Muller; and treasurer, Dr. Willis S. Hood. Dr. Converse succeeds Dr. Keitt H. Smith as president of the group.

Dr. and Mrs. John A. Workman and children moved to Durham, N. C.

Dr. Workman is studying Anesthesiology at the Duke University Hospital.

Dr. Harwood Beebe has been re-elected chief of staff at Mary Black Hospital. Others elected are Dr. Allan B. Warren, vice chief of staff; Dr. Sam Orr Black, Jr., secretary (re-elected); and Dr. Charles B. Hanna and Dr. Clarence C. Lyles, executive committee members.

ASSOCIATION'S TELEVISION PROGRAM

The medium of television is being used by the South Carolina Medical Association to give South Carolinians an opportunity to hear their community's doctors opinions and to gain a clearer understanding of current medical problems.

Through a series of informal 30-minute programs, "House Call", the doctors reach a diversified audience. This program was presented in the Charleston and Greenville areas in December where it was well received.

The initial program in the series explored the growing problem of medical care and hospitalization of the aged. Future topics for discussion will be "Food Faddism", "Rising Costs of Hospital and Medical Care", "Why Medicine is Organized", and "The Care of the American Executive."

In cooperation with television stations in Charleston, Columbia, Florence, Greenville and Spartanburg the Association plans to produce "House Call" on a monthly basis.

ANNUAL MEETING OF AMERICAN ASSOCIATION FOR THE HISTORY OF MEDICINE

TO BE HELD IN CHARLESTON,
SOUTH CAROLINA, MARCH 24, 25, 26

Papers on Historical subjects will be presented.

The Scientific sessions are open to anyone who is interested, and the Business and Social activities are open only to members of the Association.

Membership in the Association is \$6.00 per year and includes subscription to the Bulletin of the Association for the History of Medicine.

J. I. Waring, Chairman,
Committee on Local Arrangements

The guest speaker for the March Scientific Meeting of the Columbia Medical Society will be Dr. Charles P. Bailey, Philadelphia, Pennsylvania. Dr. Bailey will speak on the subject "Recent Advances in Cardiac Surgery".

The local speaker will be Dr. Buford S. Chappell, who will address the group on "Pyelonephritis".

The meeting will be held at the Columbia Hotel on Monday, March 14, 1960. The social hour will begin at 7:00 P. M., dinner at 7:45, and the scientific session at 8:30 P. M.

All interested physicians are invited to attend.

The West Virginia Academy of Ophthalmology and Otolaryngology will hold its annual meeting at the Greenbrier Hotel, White Sulphur Springs, West Virginia from April 10-12, 1960.

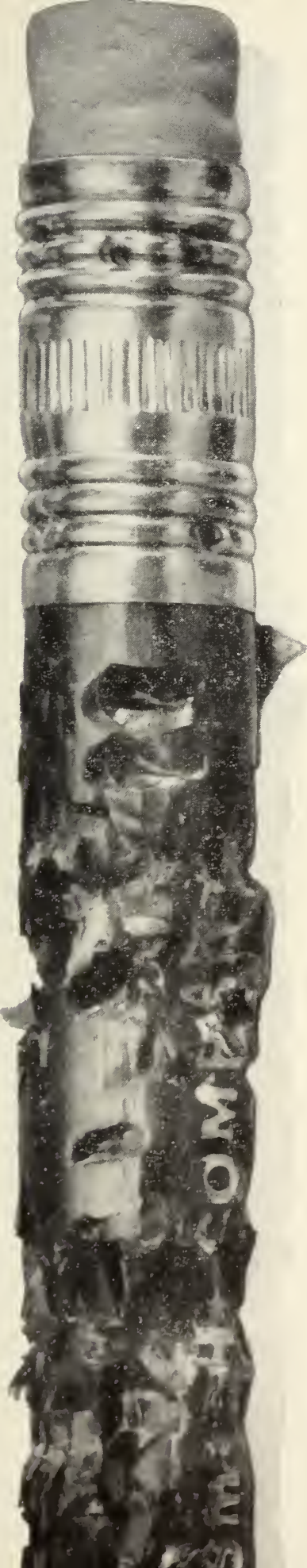
Among the guest speakers will be:

Dr. Harold G. Scheie, Professor of Ophthalmology, University of Pennsylvania.

Dr. Charles E. Iliff, Associate Professor of Ophthalmology, John Hopkins University.

Dr. Oscar T. Becker, Clinical Associate Professor of Otolaryngology, University of Illinois.

For any additional information please contact the secretary, Dr. Albert C. Esposito, First Huntington National Bank Building, Huntington 1, West Virginia.



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SEARLE

DEATHS

DR. C. P. VINCENT

Dr. Charles Pease Vincent, Sr., 76, a practicing physician for 52 years, died early Saturday morning at his home 210 Farley Ave., after several years of declining health.

He was educated at Georgia Military Academy, the Medical College of South Carolina and the University of Maryland Medical School, from which he was graduated in 1907.

Dr. Vincent had practiced medicine for 52 years in Tryon, N. C., Enoree, Sanford, Fla., and Laurens. He came to Laurens in 1914. He had been Laurens County physician for 37 years until his retirement from that post several years ago.

In 1957 Dr. Vincent was presented a Certificate of Appreciation by the University of Maryland Medical School in recognition of his 50 years of service as a physician.

DR. THOMAS B. HARPER

Dr. Thomas Bailey Harper of St. Stephen died January 6, 1960 after a brief illness. He was 64 years old.

Dr. Harper was a native of Kingstree. He was born July 10, 1895.

He was a member of the South Carolina Medical Association, the Berkeley Medical Society, the American Medical Association, and was president of the St. Stephen Lions Club. He was a Mason, and a member of St. Stephen's Protestant Episcopal Church.

Dr. Harper was vice-chairman of the board of the South Carolina Penitentiary System, and served under five governors on the board for about 15 years.

DR. A. C. BAILEY

Dr. A. C. Bailey, 94, a retired physician who was born in upper Greenville County, South Carolina, where he practiced medicine as a young doctor, died after a serious illness of two months.

After practicing for several years in Greenville County, he went to Nashville, Tenn.

He was one of the older physicians in Nashville, where he also was a Shriner and member of many organizations.

BOOK REVIEWS

BIOPSY MANUAL: James D. Hardy, M. D., James C. Griffin, Jr., M. D. and Jorge A. Rodriguez, M. D., W. B. Saunders Co., Philadelphia, 1959. Price \$6.50.

This manual describes the principles and technique of biopsy and is arranged by organ systems. It is

generously and simply illustrated with pen and ink drawings. The material presented should be of definite value to interns and surgical residents who are beginning to do biopsies. In general, the text is admirably concise, but in some areas the instructions are too incomplete for the beginner. For example, the paragraph concerning needle biopsy of the kidney amounts to a mere statement that such procedures are done. Space devoted to therapy, when unrelated to the problems of biopsy, should be conserved for more complete discussion of the primary topic. In most sections there seems to be a clear concept of the problems of the pathologist, but there are exceptions to this generality. Few pathologists, for example, would want to examine the kind of muscle biopsy recommended. After shrinkage it would be virtually impossible to get a good longitudinal and transverse section. In summary, then, this small book should be useful for teaching the fundamentals of biopsy technique but it can be improved when the authors are ready to prepare a second edition.

Forde A. McIver, M. D.

A MEDICAL HISTORY OF GREENVILLE SOUTH CAROLINA. By J. Decherd Guess, M. D. Printed by Keys Printing Co., Greenville, S. C.: 1959. Price \$5.00.

(The book may be ordered from Dr. Willis Hood, Treasurer, Greenville Medical Society, 107 East North St., Greenville, S. C.)

The *Journal* has already taken account of this excellent history of Greenville medicine in its editorial columns. It can be recommended to anyone who has an interest in the area and in the affairs of the South Carolina Medical Association. It is in pleasing format, well written, and altogether an agreeable production.

JW

NOW OR NEVER, THE PROMISE OF THE MIDDLE YEARS. 1st Ed. By Smiley Blanton, M. D. with Arthur Gordon. 273 pages. Prentice Hall, New Jersey. 1959. Price \$4.95.

This book, written for the layman, is primarily a plea for self-evaluation in the "middle years of life." A discussion of difficulties in adjusting to marriage, religion, work, sex, etc. is taken up chapter by chapter and common sense answers proposed. Numerous case histories are utilized explaining the background of many of the everyday problems that beset the average individual and an attempt made to help the person better adjust to, and control them.

Dr. Blanton has long been interested in mental hygiene, and has worked with Norman Vincent Peale in solidifying the bonds between psychiatry and religion. This book is an extension of this work and a "review of forty years of psychiatric counselling."

It is not recommended for the medical profession, but might be of value to some selected patients.

Charlton deSaussure, M. D.

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RECENT ADVANCES IN OTOTOLOGY

R. W. HANCKEL
CHARLESTON, S. C.

In the beginning surgery of the mastoid area was developed to combat infection.

This had to wait until we had developed adequate lighting and anesthesia and so did not come to pass until the latter part of the 19th century. This type of surgery flourished until the discovery of the sulfa-drugs, penicillin, and other antibiotics practically eliminated mastoid surgery in the early 1940's. At this time, surgery of the mastoid consisted of simple mastoidectomy which was designed to combat acute infections, and radical mastoidectomy which was designed to combat chronic mastoid infections. In simple mastoidectomy the contents of the middle ear were undisturbed and some hearing was preserved. In radical mastoidectomy the drum and most of the contents of the middle ear were removed and thereby about 25 per cent of hearing was destroyed.

Antibiotic drugs to combat mastoid infections offered the patient a more economic and less painful solution to his problem and this has become the method of choice in treating infections of the mastoid.

Surgery of the mastoid area is now being developed to combat deafness. The deafness may be the result of chronic infection or may come from otosclerosis, a benign overgrowth of bone at the footplate of the stapes. It is designed to rehabilitate the deaf individual in contrast to the first type of surgery of the mastoid which was designed primarily to combat infection.

Taking up these latter surgical procedures in the order of their development, we find that Lempert¹ in 1938 was the first to develop

a one-stage fenestration operation. Before him, Holmgren² in Sweden, Sourdille³ in France, and others had perfected a two-stage fenestration procedure. Lempert's operation is used mainly in the treatment of clinical otosclerosis where an overgrowth of bone around the footplate of the stapes immobilizes the small bones of the middle ear and prevents sound waves from being conducted to the nerve of hearing. The nerve itself is intact. The main objection to the fenestration operation is that it eliminates the utilization of the ossicular chain and thereby destroys about 25 per cent of hearing at the outset. A new window is made in the horizontal semi-circular canal. This allows sound waves to enter the inner ear near the first turn of the cochlea and the waves are then conducted to the end-organs of Corti by the fluid in the inner ear. The stapes with its footplate ankylosed in the oval window is simply bypassed and the ossicular chain, already nonfunctioning by reason of this ankylosis, is completely eliminated as a functioning part of the hearing mechanism by the removal of the incus and the head of the stapes. Airborne sound waves now enter the canal, strike the membrane covering the new window and at this point become converted to fluid-borne waves. They stimulate those particular hair cells in the organ of Corti which their pitch calls for and pass on through the coils of the cochlea to spend themselves at the round window. The round window is also covered by a semi-elastic membrane. If this membrane is rendered immobile, for instance by the presence of otosclerotic bone or adhesions in the round window niche, then the fluid in the

inner ear becomes almost completely immobile also and so only a few waves of low amplitude are produced in the inner ear, the stimulation of the hair cells is minimal, and the patient has about a 40 per cent loss of hearing. If both windows are blocked, there is no motion of the fluid in the inner ear and the patient has a complete loss of hearing even though the nerve itself is intact.

The rediscovery of the operation to mobilize the stapes was an accidental one. Dr. Samuel Rosen⁴ of New York was doing a fenestration operation under a local anesthetic. He exerted pressure on the head of the stapes to test its mobility and felt it give a little. The patient immediately said that his hearing was greatly improved. He perfected this operation using local anesthesia and an endaural approach to the stapes, which he mobilized by exerting pressure on its head. The chief advantage of this procedure is that it preserves the ossicular chain and so the patient does not lose 25 per cent of hearing at the outset. Rosen published his paper in 1955. He used a loupe for magnification. The loupe has given way to an operation microscope. There have been many modifications of his original technic. It was soon found that a good result was obtained in only about one-third of the cases because the crura of the stapes were so easily fractured. Also even though a good result was obtained at the time of operation, regrowth of otosclerotic bone around the footplate converted about one-half the immediate good results into later poor results. In an effort to improve these poor results Rosen's original technic has been modified so that now, using the operation microscope, the footplate of the stapes is attacked and pressure is exerted here instead of at the neck. This eliminates the possibility of fracturing the crura and has increased the immediate good results from about 35 per cent to 70 per cent. Also the late poor results have been decreased by pressing the footplate of the stapes inward slightly so that the periphery of the footplate is just below the level of the rim of the oval window.

However, working on the footplate itself also has certain disadvantages. Sometimes the footplate is pushed inward too vigorously and ends up at the bottom of the basal coil of the

cochlea. Besides increasing the deafness, this also produces a positional vertigo, so that every time the patient changes the position of his head, the stapes moves and sets up waves in the perilymph which stimulates the end-organs of balance and produces a momentary vertigo. This vertigo is not permanent, but passes away after several months. Fortunately this is not a frequent complication.

If the otosclerosis is rather extensive and visualization of the footplate of the stapes is difficult, the crura may be deliberately removed and after the footplate is mobilized, a polyethylene strut is substituted for the crura. It extends from the lenticular process on the under surface of the incus to the footplate of the stapes and re-establishes the continuity of the ossicular chain. This procedure can also be used where the crura have been fractured as the result of exerting pressure on the neck of the stapes after the original method of Rosen.⁴ It is a very satisfactory addition to our surgical armamentarium.

The regrowth of the otosclerotic process around the footplate after mobilization (even repeated mobilizations) has been quite a problem. This has been overcome to a great extent by the vein graft technic of Dr. J. J. Shea, Jr.⁵ of Memphis, Tenn. He uses a bur to flatten the promontory and remove the otosclerotic focus. He then thins the footplate of the stapes and removes it. He lays a segment of vein previously obtained from the back of the hand over the oval window and surrounding area and then re-establishes the continuity of the ossicular chain by laying a polyethylene strut between the lenticular surface of the incus and the vein graft. The outer or adventitia surface of the vein is roughened and laid over the oval window and the inner or intima surface faces inward and receives the end of the polyethylene tube. Guilford at a recent meeting of the North and South Carolina Eye, Ear, Nose, and Throat Societies reported about 90 per cent good results using this technic.

Other operative procedures designed to combat chronic infections and to restore hearing have recently been devised by Wullstein⁶ and others. They are termed tympanoplasties and have been divided into five types

depending on the amount of destruction of the ossicular chain due to infection. These patients have a perforation of the drum and usually have some type of aural discharge present. In order to eliminate the infection a mastoidectomy is done as a preliminary procedure. The remnants of drum and as much of the ossicular chain as possible are preserved. Using the operation microscope, the external layer of the drum is removed and a full-thickness skin graft, obtained from the post-auricular area, is laid over the denuded drum remnants and is brought into contact with some portion of the ossicular chain, provided the stapes is mobile. If the stapes is immobile, either because of adhesions or otosclerosis, or both, then a fenestration is done either at the time of the original operation or as a secondary procedure. It must be remembered that in any type of middle ear surgery the round window must be open. If it is blocked on account of adhesions or an overgrowth of otosclerotic bone, then no matter how nice a result is obtained at the oval window area there will be a minimal movement of fluid in the inner ear and the patient will still have a 40 per cent hearing loss.

Rambo⁷ has recently come out with a modification of the tympanoplasty which he calls a musculoplasty. This is used only in those cases where chronic infection has produced a complete destruction of the ossicular chain necessitating a fenestration as a secondary procedure. In these cases Rambo reflects the skin of the canal upward, fashions a pedicle graft from the lower portion of the temporal muscle, and directs the free end of the pedicle downward and medially so that it covers the middle ear area. The skin of the canal is now replaced and comes to lie on top of the muscle. This allows a more adequate blood supply for the skin and so a more rapid epithelialization and a better nourished epithelial covering. The canal is filled with a special paraffin having a low melting point and this remains in place for about 8 weeks. The object of the paraffin is to thin out the muscle with its epithelial covering so that this skin flap will not be too thick when it is used to cover the window in the secondary fenestration operation.

As a result of all of this increased surgery in the middle ear area we have advanced our knowledge of the hearing mechanism. I will not bore you with a recital of the various theories of hearing because in the final analysis we don't know exactly how hearing is accomplished. Suffice it to say that air-borne sound waves are conducted to the drum membrane and are transmitted and magnified by the ossicular chain. They reach the oval window where they become fluid-borne. The fluid waves produce vibrations in the basilar membrane and this causes the hair cells to rub on the under surface of the tectorial membrane. These stimuli are transmitted to the nerve fibers which go to the spiral ganglion and so to the acoustic nerve and the brain. Whether sound is analysed in part or in toto in the inner ear or in the brain, is still unknown.

The function of the round window is twofold. It serves as a relief opening to permit maximum movement of the perilymph. In the pathologic ear where the stapes is fixed it may serve as the portal of entry for sound. Sound protection is furnished the round window by the intact drum membrane. If a large perforation is present in the drum membrane and the stapes is mobile, sound enters the inner ear at both portals and the sound waves going in opposite directions meet in the cochlea and tend to cancel each other out. Thus sound protection for the round window will increase hearing provided sound waves can enter at the oval window end of the cochlea.

Time does not permit us to pursue this fascinating subject further. I hope that it has served in some small measure to bring you up to date on things otological.

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TRAUMATIC SUBCUTANEOUS RUPTURE OF THE STOMACH

WENDELL M. LEVI, JR., M. D.

SUMTER, S. C.

I. Introduction:

Subcutaneous or "subparietal"¹⁵ rupture of the normal stomach although not extremely rare, occurs infrequently enough to warrant consideration of individual cases. While subcutaneous rupture of other intra-abdominal viscera is relatively commonplace and has received adequate attention, there remains a paucity of case reports and survival data incident to post-traumatic rupture of the stomach.

Petry¹¹ in 1896 collected 219 cases of rupture of the gastrointestinal tract with 13 cases of traumatic rupture of the stomach. Eisen-drath⁵ in 1902 reported 165 cases of gastrointestinal injury with no case of stomach injury. Glassman,⁹ in a comprehensive review of the literature collected 52 cases of subcutaneous rupture of the stomach and added two of his own. Wolf¹⁵ in 1936 again surveyed the literature and collected 68 cases, and added one of his own. Only sporadic reports have appeared since that time, as may be seen from the references below.^{1-4, 6, 7, 10, 12-14}

II. Case Report:

A three year old white male was admitted October 9, 1958, brought immediately to the Emergency Room, after sustaining a fall from a second story floor and landing upon a concrete pavement. He was unconscious for a very short period of time. His temperature was 99°F., pulse 180 per minute, and blood pressure 110/80 mm. Hg. The child was lethargic and extremely pale with rapid respiration and in obvious distress. Abrasions were visible over the anterior abdominal wall, especially in the left upper quadrant. The abdomen was markedly distended with prominent veins over its surface. No peristaltic sounds were heard. There was marked generalized tenderness, rebound tenderness, and muscle guarding. The area of liver dullness was absent.

The hemoglobin was 11.5 Gm. with a volume of packed cells of 29 volumes percent. X-ray examination of the abdomen in the upright position (Figure #1)



Figure 1

An upright x-ray film of the abdomen and chest revealing marked free air beneath the diaphragm.

revealed a large amount of free air beneath the diaphragm. Roentgenograms of the skull showed no evidence of a fracture.

Hospital course: The patient was seen by the surgical service approximately two hours after the injury. A venesection was performed and the child taken immediately to the operating room.

Under general endotracheal anesthesia, the abdomen was opened through a midline incision. A considerable quantity of free air was present in the peritoneal cavity along with approximately one liter of gross food material including chicken, rice, and beans. There

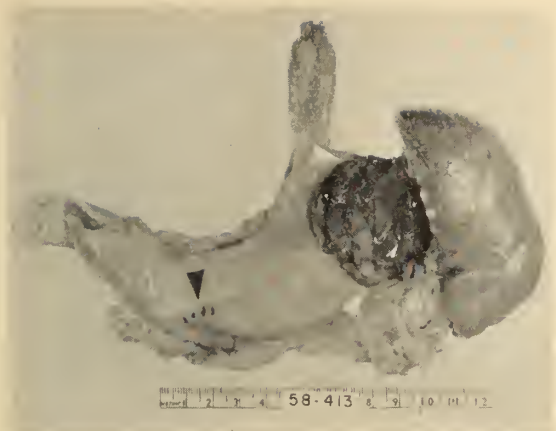


Figure 2

The stomach and attached structures removed at autopsy. The white arrows mark the extent of rupture of the greater curvature. The black arrow marks the site of closure of a serosal tear.

was a 6 cm. longitudinal tear of the greater curvature of the stomach extending to the splenic hilum. (Figure #2) No bleeding was evident from the laceration. The rupture was rapidly closed in two layers, and the peritoneal toilet carried out using saline and Hartmann's solution. An effort was made to remove all gross food material. The blood pressure remained approximately 120 to 130/80 mm. of Hg. throughout the procedure with a pulse of 180 to 200 per minute. The procedure was otherwise tolerated quite well with a postoperative volume packed cells of 47 vol. %, after the infusion of 600 ml. of whole blood.

The postoperative course was complicated by temperature elevations ranging from 104 to 105° despite intravenous, intramuscular, and intraperitoneal antibiotics. The child remained restless but alert and there was approximately 100 ml. of urine output during the first ten hours. The urine output remained 10-15 ml. per hour despite a blood pressure drop to unrecordable levels. Despite vasopressors and hydrocortisone the child progressed to extreme toxicity with generalized convulsions and marked hyperthermia. He remained hypotensive and terminally developed respiratory irregularities prior to the disappearance of the apical heart beat. He was pronounced dead approximately 36 hours postoperatively. (October 11)

Post mortem examination revealed no abnormality of the peritoneal cavity other than mild resolving peritonitis. The operative closure of the stomach was intact. On gross examination of the brain, there was some flattening of the gyri and shallow sulci, but microscopic examination failed to reveal significant cerebral edema. There was a small area of apparent necrosis involving the hippocampal gyrus on the right. The post mortem examination was otherwise non-revealing.

III. Discussion:

Injury to the intra-abdominal viscera pro-

duced by blunt trauma most commonly involves those organs which are relatively fixed or readily subjected to compression against adjacent solid structures. Consequently, we see rupture of the duodenum, proximal jejunum, distal ileum, and cecum most frequently. The stomach, unlike these viscera, is well-protected over most of its surface by the overlying abdominal wall, rib cage, diaphragm, transverse colon, lower part of the left lung, spleen, and left lobe of the liver. It logically follows that rupture of the stomach will be associated with injury to other organs and severe trauma in a large percentage of cases. Stomach rupture is frequently associated with fractures of the liver or spleen and uncommonly with rupture of the left leaf of the diaphragm.

The antrum and pylorus are relatively superficially located beneath the abdominal wall, and lie adjacent to the vertebral bodies. Therefore, rupture in this area frequently results from "crushing type" injuries. Although complete tears of the stomach have been reported, the trauma is usually severe and immediate death commonly results from associated injuries.

There are three main types of injury to the stomach:

1. Bursting
2. Crushing
3. Tearing or shearing injury.

These may result in tears of a varying nature.

1. Serosal tears
2. Mucosal tears
3. Scrosal and submucosal
4. Complete rupture of the wall
5. Complete division of the stomach

In the "bursting type" injury the factor of distention is extremely important. Trauma of a mild to moderate nature may cause rupture of the stomach distended with food. Here the rupture usually occurs on the lesser curvature proximal to the pylorus, or on the greater curvature distal to the vasa brevia. Contamination is extensive as in the presented case. Fraenkel⁸ was able to produce typical rupture of the normal stomach along the lesser curvature, and concluded that it was due to

the anatomical variations in mucosal folds and the elasticity along the lesser curvature. Studies by others have not been conclusive.

The "tearing" injury is associated with a shearing action at the point of fixation and usually occurs in the prepyloric area.

Serosal injury is usually not symptomatic and is commonly discovered at exploration for other injury. Mucosal tears in most instances are associated with intra-gastric bleeding and hematemesis. Complete rupture of the wall or complete division of the stomach presents a predominant picture of shock and generalized peritonitis. The degree of symptoms is related to the amount of peritoneal soiling. The diagnosis is suspected in the presence of a large amount of free air in the peritoneal cavity with an associated injury in the left upper quadrant in the presence of the above symptoms.

Survival reports prior to operative intervention were those with small incomplete tears which were rapidly sealed off. Later complications of fistulae, adhesions, or abscesses may have confirmed the diagnosis.

Although occasional survivors with massive soiling have been reported, most reports failed to give an accurate description of the amount of soiling or extent of rupture. The associated

injuries, the interval from rupture to operation, the degree of soiling, and the general condition of the patient are all important factors in prognosis. No conclusion as to the mortality or associated morbidity can be gleaned from the literature as the cases are too frequently poorly described and sporadic.

The treatment in all incidences of diagnosis of rupture of the stomach is operative. The usual preparation for emergency surgery is essential; namely fluids, blood, naso-gastric intubation and antibiotics. Laparotomy is performed through a satisfactory vertical incision. Peritoneal toilet should be vigorous but quickly accomplished. The removal of gross food particles and flushing of the peritoneal cavity with saline solution, especially in the sub-hepatic, subdiaphragmatic, and pelvic spaces is considered valuable. Further clinical experience with cortisone in the treatment of hypotension secondary to massive peritonitis and septicemia is inviting.

IV. Summary and Conclusions:

Subcutaneous rupture of the stomach is an uncommon injury which may result from minor or severe trauma. A brief discussion of this clinical entity and a case report are presented.

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COEXISTENT SICKLE CELL DISEASE AND ACUTE RHEUMATIC FEVER

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COLUMBIA, S. C.

The diagnosis of acute rheumatic fever is frequently difficult,¹ and the problem may be made even more perplexing by the co-existence of another disease which produces changes in the heart and blood vessels. The anemia of sickle cell disease is frequently intense enough and of sufficient duration to produce cardiac symptoms and signs of such degree that the disease is often confused with rheumatic fever. The occurrence of the two diseases in the same patient appears to be extremely rare; a review of the literature yields only 5 cases of sickle cell anemia in which valvular defects or Aschoff bodies due to rheumatic fever were found at autopsy.²

The importance of recognizing the co-existence of rheumatic heart disease when it is present in patients with sickle cell disease is self-evident. Not only is it a challenge to our diagnostic ability to evaluate properly the clinical and laboratory findings upon which we rely in the diagnosis of rheumatic fever, but the prognosis of either disease may be altered by the presence of the other.

The purpose of this paper is to present the clinical and laboratory findings of a patient who is thought to have co-existent sickle cell disease and acute rheumatic fever.

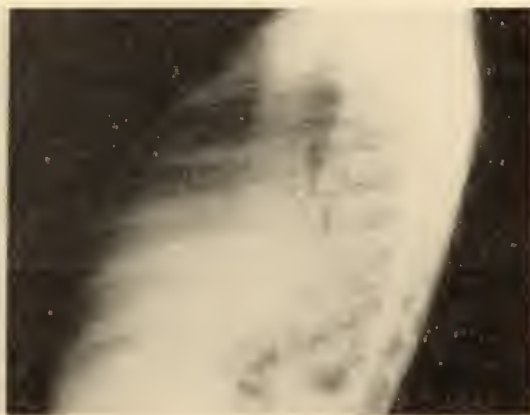
Case Report

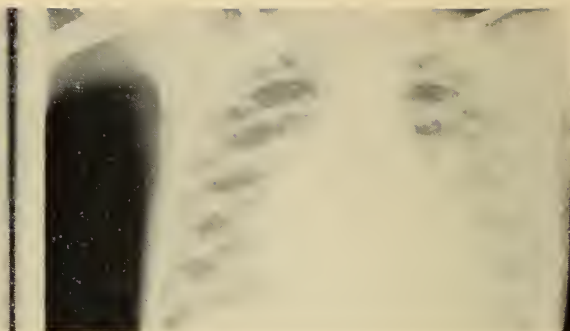
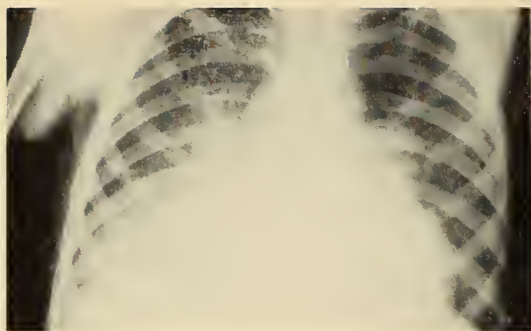
A 7 year old colored male was referred to the Rheumatic Fever Clinic with a history of heart mur-

mur and pain in the knee and elbow joints. He had had three previous admissions to the hospital for treatment of sickle cell crisis, the first at the age of 3 years. On the first admission no cardiac murmur was recorded. One year later on the second admission there was noted a soft grade I apical systolic murmur; the spleen was palpable 4 cm. below the left rib margin, and the liver was palpable 3 cm. below the right rib margin. On third admission in sickle cell crisis at six years of age, a harsh grade II apical systolic murmur was heard over the entire precordium; the liver edge was palpable 5 cm. and the spleen was palpable 4 cm. below the rib margins. Chest roentgenogram taken on this admission is shown in Fig. 1.

Family history is remarkable in that the mother had sickle cell disease and died in sickle cell crisis at the age of 30. There are two siblings residing elsewhere with history of the diagnosis of rheumatic heart disease, and a maternal aunt with history of a diagnosis of rheumatic heart disease.

On this admission to the hospital at age seven this boy complained of pain in the knees, elbows, chest and abdomen, shortness of breath, and high fever. On admission the temperature was 103° F. and there were physical findings of consolidation of the right lung. X-ray examination confirmed the presence of pneumonia. The heart was generally enlarged with a rough grade III apical systolic murmur and a grade I aortic diastolic murmur; this murmur was not felt to be a Graham-Steele murmur. The pulmonic second sound greatly accentuated. Pulse 120/min. Blood pressure 100/80 mm. Hg. in upper extremities and 120/85 in lower extremities. The extremities were long and slender but otherwise normal. There was severe anemia (6.8 grams or 43% hemoglobin) with a marked leukocytosis of 46,000 cu. mm. with 55%





neutrophils. The patient was thought to be in sickle cell crisis.

Additional studies showed 90 and 60 percent sickling on two occasions and sickle cell disease was proven by electrophoretic hemoglobin determination. The electrocardiogram showed first degree heart block with a prolonged P-R interval, notched P waves in leads II and III suggesting left auricular disease, and in the multiple precordial leads the RS ratio was reversed and T waves inverted suggesting right ventricular enlargement. Later tracings were essentially unchanged except for shortening of the P-R interval after digitalis therapy. Roentgenogram of the chest and flouroscopy with barium swallow revealed globular enlargement of the heart with enlargement of the left atrium.

On admission the patient was started on digitalis and penicillin. During the hospitalization the pneumonia improved. Except for two episodes of pain, heat, and tenderness in the left elbow and left knee joints the arthritis subsided. The first episode of joint pain occurred 17 days after admission to the hospital, and there was no evidence of sickle cell crisis at this time. Both episodes of arthralgia responded well to salicylate therapy. The hemoglobin and reticulocyte count did not respond to massive doses of iron and ascorbic acid.

Laboratory data tabulated as follows:

Date:	Sed. Rate Uncor.	Cor.	Anti-Strep. Titer	C-React. Protein
March 5	12mm/hr.	0mm/hr.		
March 10	44	22	1250 Todd Units	
March 12	33	24	2500	
April 2			2500	
April 13	29	17	333	
April 23	34	9	250	Neg.

Discussion

Since Herrick's description of sickle cell anemia in 1910 there have been many articles in the literature dealing with the clinical and pathological findings of this disease.³ Sickle cell anemia, which notoriously stimulates many systemic diseases, also imitates cardiac

diseases. The histories of cases of acute rheumatic fever and sickle cell anemia in crisis are often similar. In both, an upper respiratory infection may precede the complaints of headache, epistaxis, chest pain, abdominal pain, joint pain, fever, exertional dyspnea, palpitation, and leukocytosis. On physical examination both diseases frequently show an enlarged heart and murmurs characteristic of mitral insufficiency. Prolonged auriculo-ventricular conduction time may be found on the electrocardiogram.

Due to the similarity, rheumatic heart disease with mitral valvular involvement is frequently diagnosed in patients with sickle cell anemia. In Higgin's series, 62 cases of sickle cell anemia were reviewed and 22 of these were initially diagnosed as having rheumatic heart disease.⁴ A similar study by Aaron of 85 patients with sickle cell anemia showed that 30 of these patients had had previous diagnosis of rheumatic heart disease.⁵

A requirement for the diagnosis of sickle cell disease is the finding of sickling or the pattern of hemoglobin as determined by electrophoretic studies. The diagnosis of rheumatic fever is often based on certain "major" and "minor" criteria as set down by Jones.⁶ The major criteria include, briefly: (1) carditis as manifested by cardiac enlargement, significant cardiac murmur, pericarditis, or cardiac failure; (2) arthralgia - migratory polyarthritides; (3) chorea; (4) subcutaneous nodules; and (5) recurrence of rheumatic fever or erythema marginatum. According to Jones a diagnosis of rheumatic fever is justified in a given case if two major manifestations are present. He also states that a combination of one major

and two minor manifestations would seem to place the diagnosis on reasonably safe grounds.

Although many of the symptoms and findings of the two diseases are similar, closer observation and evaluation will often show shades of differences in the clinical and laboratory findings which help in the differentiation. Both diseases show migratory, hot, swollen, painful extremities; however in sickle cell anemia the extremity pain is not localized to the joints as in rheumatic fever but also involves the long bones. The subperiosteal reaction may even be severe enough to produce pathological x-ray findings. The pain in sickle-mia does not respond to salicylates as it does in rheumatic fever.^{7, 8}

The sedimentation rate of patients with sickle cell anemia is known to be slow. This delay in the sedimentation rate seems to be related to the degree of carbon dioxide saturation of the blood; the higher the saturation the slower the rate.^{9, 10}

As rheumatic fever is known to be closely associated with a recent beta hemolytic streptococcal infection the findings of a persistently positive antistreptolysin test in conjunction with clinical evidence of carditis is strong evidence of the presence of active rheumatic fever.¹¹

Sickle cell anemia may produce abnormalities of the electrocardiogram which are similar to those observed in rheumatic fever. Some authors consider a prolonged P-R interval a characteristic feature of active rheumatic heart disease; however, Klinefelter demonstrated this finding in 50 percent of his cases with sickle cell anemia.¹² T-wave changes frequently occur and right axis deviation, although not often found may appear in patients with sickle cell anemia who do not have valvular defects. However, frank evidence of myocardial damage as shown by the ECG was not seen in any of the cases of sickle cell anemia reviewed in the literature. Broad peaked P-waves usually found with atrial pathology are not seen in sickle cell disease.^{4, 7, 13, 14} The configuration of the heart as shown by x-ray in sickle cell anemia as a rule is globular, but the so-called "mitral heart" with the prominent pulmonary

conus is not at all unusual. Cardiac fluoroscopy with barium swallow of the patients with sickle cell disease does not reveal left atrial enlargement usually found in patients with mitral valvular disease.^{4, 7, 13}

The cardiac murmurs associated with sickle cell disease have been described as functional; i.e. there are no specific valvular lesions *per se* attributed to sickle cell disease. In Higgin's report of 62 cases of sickle cell anemia the following cardiac murmurs were heard:⁴

Mitral systolic	44	Mitral diastolic	7
Pulmonary systolic	20	Pulmonary diastolic	1
Aortic systolic	7	Aortic diastolic	0
Thrill felt over mitral area			1
No murmur heard			17

One of the important clinical characteristics in the terminal stages of sickle cell anemia in heart failure is the absence of response to digitalis.^{4, 14}

Conclusion

A diagnosis of sickle cell disease was evident in this case on the basis of history, positive sickling on two occasions (90 and 60 percent), electrophoretic hemoglobin pattern for sickle cell disease, and persistent anemia without response to massive iron and ascorbic acid therapy.

A diagnosis of acute rheumatic fever was thought justified in this case on the basis of the following physical findings which satisfy two major manifestations: (1) Carditis as evidenced by cardiac enlargement with heart failure, cardiac murmur, and good clinical response to digitalis therapy; (2) arthritis-migratory in nature involving elbow and knee joints, with the clinical response of arthralgia to salicylate therapy.

Additional evidence to support the diagnosis of acute rheumatic heart disease was the laboratory finding of a persistently elevated sedimentation rate, even in the presence of sickle cell disease, strongly positive anti-streptolysin titer and C-reactive protein. Also the patient showed ECG changes which suggested left auricular disease and those findings more indicative of acute rheumatic fever than sickle cell disease alone. Further evidence of rheumatic fever was shown by enlargement of the left atrium. The co-existence of sickle cell disease and rheumatic heart disease, although extremely rare, does occur. A diagnosis of the

two diseases can be justifiably made from clinical and laboratory findings although it may only be proven at autopsy.

The authors wish to acknowledge the assistance received from Dr. C. Warren Irvin, Jr., Consultant in Cardiology.

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CYSTOSARCOMA PHYLLODES*

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Cystosarcoma phyllodes is a giant tumor of the breast, probably by metamorphosis from a benign fibroadenoma. There have been about 300 cases reported in the literature.

The purpose of this presentation is to review some of the salient features of this relatively rare neoplasm and report two additional cases.

This confusing breast tumor is generally called cystosarcoma phyllodes but as each enthusiastic author reviews its pathology and course, he assumes his prerogative and applies another name. Stephenson et al⁷ found 43 synonyms and Botham¹⁷ in 1958 added another. The general confusion lies in the histological picture and whether the tumors are benign or malignant. The following are some of the many names: giant myxomatous fibroadenoma, adenocystosarcoma, Brodie's serocystic disease of the breast, carcinosarcoma, giant intracanalicular myxoma, fibroadenoma with sarcoma-like stroma and many

Cystosarcoma phyllodes is the generally accepted name of at least 44 used to designate a giant tumor of the breast, probably having grown from a pre-existent fibroadenoma. There is occasionally a malignant change in the connective tissue stroma which may result in blood stream metastasis to the lungs, etc. There are reported cases of malignancy in the epithelial components with axillary node metastasis. The tumor occurs in women (three only in men) about 40 to 45 years old, grows rapidly, is painless (unless ulcerated), unattached to the skin, occupies almost all of the breast and the nipple is usually uninvolved. The average weight in 229 cases was 7.6 pounds. The largest recorded is 35 pounds. Simple mastectomy seems to be choice of operation. Local excision has resulted in more local recurrences and x-ray therapy is not indicated. Two cases are reported to add to the 300 odd recorded.

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others including finally fibroadenoma intracanalicular sarcomatodes xanthomatodes mammae!

Johannes Müller in 1838 first described this tumor and his descriptions are as accurate as those today. He felt very strongly that the tumor was benign. Ten years before this, Celius is said¹¹ to have described such a tumor and called it "cystic hydatid of the breast". Goodall and Curren⁶ give reference to William Cumin's article in the *Edinburgh Medical and Surgical Journal* of 1827 where he describes the condition and reports a case with a 57½ ounce tumor. Sir Astley Cooper in 1828 had termed it an "encysted tumor of the mamma", which is always benign, and will not recur. Cumin agreed but this has not proven to be so in our present knowledge. At the time of its naming "sarcoma" meant "fleshy mass" and "phyllodes" from the Latin means "leaf-like".

Incidence

Lee and Pack¹ in 1939 first summarized the literature and collected 109 cases. Treves and Sunderland⁶ reported 77 cases in 1951 and in 1958, Botham et al¹⁷ reviewed the 22 cases from the Mayo Clinic in a 50 year span (1907-56). Huang and associates¹⁵ counted 250 cases in 1957 and reported 11 additional. Reich¹⁰ thinks about 300 cases have been recorded up to January 1958.

The incidence varies according to whether all breast tumors are considered or merely fibro-epithelial tumors. Fred Stewart feels that this tumor is a museum curiosity.

The tumor occurs mainly in women although three cases¹ have been seen in men. The average age is 40-45 years, the youngest being 13¹ and the oldest 83.¹⁵ There is some feeling that the etiology is related to estrogenic hormone, and this will be mentioned later.

Pathology

Müller's 1838 description of this condition as quoted by Silverstone¹¹ is as follows:

"The tumour forms a large mass with a more or less uneven surface. The fibrous substance which constitutes the greater part of it is of a greyish white colour, extremely hard and as firm as fibro-cartilage. Large portions of the tumour are made up entirely of this mass, but in some parts are cavities or clefts not lined with a distinct membrane. These cavities contain but little fluid; for either their parietes which are

hard like fibro-cartilage and finely polished lie in close apposition with each other, or a number of firm, irregular laminae sprout from the mass and form the wall of the fissures, or excrescences of a foliated or wartlike form sprout from the bottom of the cavities and fill up their interior. These excrescences are perfectly smooth on the surface and never contain cysts or cells. The laminae lie very irregularly and project into the cavities and fissures like the folds of the psalterium in the interior of the third stomach of ruminant animals. In one instance the author saw these laminae here and there regularly notched or crenated like a cock's comb. Sometimes the laminae are very small and the warty excrescences from the cysts very large, while in other instances both are greatly developed. Occasionally these warty excrescences are broad, sessile, and much indented; others have a more slender base and somewhat resemble cauliflower condylomata. Tumors of this kind attain an enormous size, hitherto the author has seen them only in the female breast nor are they even there of frequent occurrence. They are decidedly innocent, occur earlier than is usual for cancer in the mamma to develop itself, and sometimes they appear even in youth; they have but little tendency to grow to the skin or to the adjacent muscles and are not attended with retraction of the nipple. They are not disposed to soften internally, but continue to grow slowly until they have attained an enormous size when they at length burst and a very ill-looking, suppurating fungus forms upon their surface. Even in this state, however, operation has been performed with a successful result. Swelling of the axillary glands is not a common occurrence and when it is met with is the consequence of simple irritation and subsides after the operation. The extraordinary forms which cystosarcoma phyllodes assumes at once suggests the notion of its cancerous nature, and yet the disease is perfectly innocent and as far removed from carcinomas as are those non-suppurating cauliflower condylomata of the penis and of the female genitals which have so often been mistaken for cancerous structures."

The question of malignancy has furnished many views. Stewart¹⁶ feels that cystosarcoma phyllodes *per se* does not mean a malignant tumor and should imply a benign lesion unless further qualified. He feels that the real difference between intracanalicular fibro-adenoma and the giant form which is cystosarcoma phyllodes is principally one of size, not only the size of the tumor as a whole, but also the size of the individual intracanalicular components. Therefore, when one sees a large, encapsulated tumor with tremendous intracanalicular projections, there is no question of the applicability of the term cystosarcoma phyllodes. The smaller tumors have coarser intracanalicular protrusions and these he

calls "miniatures". Usually when malignancy occurs, the connective tissue components and not the epithelial elements are involved. In exceptional instances, both types may participate in the malignant process and then a true adenosarcoma or carcinosarcoma develops. This view of histogenesis is supported by the clinical behavior. Those that develop sarcomatous elements cause death by bloodstream metastasis while those with malignant epithelial changes develop nodal metastasis. When there is epithelial malignancy in the primary growth, both types of disease might appear in the lymph nodes. As experience grows, Stewart seems to be more suspicious of cystosarcoma phyllodes as being malignant.

McDonald and Harrington⁴ feel that other than in size, this tumor is little different from a fibroadenoma, and usually almost all of the breast is involved. Histologically, they think that there is more myxomatous degeneration than is usually seen in fibroadenoma. They also consider the possibility of multicentric origin in the fibroadenoma.

Treves and Sunderland⁶ feel that the word "benign" or "malignant" should follow a diagnosis of cystosarcoma phyllodes. They had 18 cases of malignancy out of 77. Nine of these metastasized and 8 caused death.

Farbman⁸ thinks the tumor is essentially a hyperplasia of the connective tissue stroma with little epithelial involvement. The stromal change is characterized by atypical cells and mitosis which determines the degree of malignancy. He collected 229 cases with an average weight of 7.6 pounds. Goodall and Curren⁸ say that Hunter had a 16 pound tumor which had not been previously reported. Lee and Pack¹ found that Horton and Baker had a tumor weighing 6,960 grams and Mosconi one weighing 7,250 grams. MacKenzie (quoted by Huang *et al*¹⁵) had a tumor weighing 35 pounds.

Lester and Stout¹⁰ give a histological picture with several impressive features i. e.

1. There is marked variation of the stromal pattern in a single tumor. It varies from a well differentiated to an anaplastic sarcoma throughout or from dense acellular stroma to an anaplastic sarcoma. This emphasizes the importance of studying many parts of the

tumor. This variation also accounts for the supposition by some that all these tumors arise in pre-existent, innocent fibroadenomas.

2. There is marked variation in the architecture from cellular fibroadenomas of the pericanalicular variety to intracanalicular fibroadenomas to tumors with pronounced stromal over-growth in which large areas are without epithelial or glandular patterns.

3. The proliferating stroma often assumes the characteristics of mesenchymal tumors other than fibrosarcoma. Myxomatous, cartilaginous, and osteoid foci are not unusual. Lipoblastic portions have also been seen.

4. The marked variation in cellularity and pattern have made the grading of the degree of malignancy, if any, very difficult. They question whether a small anaplastic focus in an otherwise well differentiated stroma should really imply malignancy.

Diagnosis

As is obviously seen by the foregoing, the name, pathological picture, and course of this disease is in a state of utter confusion.

In general, it may be said that a breast tumor which grows rapidly (one weighed 7 pounds in a period of three to four months¹) is painless, unattached to the skin, has no nipple discharge or palpable axillary nodes, and occurring in a woman 40 to 45 years old, is probably a cystosarcoma phyllodes. If removed by local excision and sectioned in the operating room, there is no other tumor similar to it.

Botham's¹⁷ criteria for histological diagnosis is "a benign epithelial component within a primary tumor mass, the stroma of which is richly cellular." He feels these criteria indicate that a fibroadenoma is the fundamental lesion. He also wonders whether a sarcomatous metamorphosis of a benign to a malignant stroma has ever been followed, and thereby to describe, what is or is not an early malignant change may be impossible.

The relation of trauma, pregnancy, puberty, lactation and the menopause have been mentioned by several^{3,15,19} but no definite conclusions have been drawn. Huang *et al*¹⁵ suggest that the change in ovarian function (pregnancy, lactation, etc.) may cause a fibroadenoma to begin growing. Geschieter and Copeland^{3,16} have long believed that estrogenic substances have a great influence on fibroadenomata of the breasts.

Treatment

Generally a simple mastectomy is the treatment of choice in cystosarcoma phyllodes even though some have advocated a radical mastectomy.^{6,16}

In reviewing various articles one finds no unanimity of opinion. For instance, in the 22 cases at the Mayo Clinic¹⁷ 14 had a radical mastectomy and five of these additional x-ray therapy. Only four cases had simple mastectomy without further therapy (as x-ray or axillary dissection) yet simple mastectomy is now thought to be an adequate operation at that institution.

Lee and Pack¹ advocate simple mastectomy with excision of the pectoral muscle fascia. They caution against local excision and also against x-ray therapy.

Treves and Sunderland⁶ had 18 malignant cases (in 77). Sixteen of these were removed locally or by simple mastectomy and either recurred or metastasized. Therefore, if the tumor is thought to be malignant initially, they advocate a radical mastectomy.

Stewart¹⁶ advocates a radical mastectomy if malignant epithelial cells are present, however, if after a painstaking study, only malignant connective tissue is revealed a simple mastectomy is sufficient. He then hedges by saying a radical mastectomy may be safer for the tumor may have extended beyond its capsule.

Cooper and Ackerman¹¹ report a case with axillary metastasis.

Lester and Stout¹⁰ had five fatal, malignant (metastasizing) cases (out of 58). Two of these were diagnosed borderline malignancy and one had a simple mastectomy and the other local excision. Another was considered benign and was treated by x-ray before metastasis.

Farbman⁸ reported a case where a 6 x 5 cm. encapsulated tumor recognized for eight days was excised and diagnosed as "a malignant fibrous connective tissue tumor" by one pathologist and "a spindle cell sarcoma arising from an intracanalicular fibroadenoma . . . of local malignancy only" by another. In two months an encapsulated tumor of the same size recurred and a simple mastectomy was

done. The tumor recurred in two and one-half months in the scar and at this time there was no capsule and at operation the tumor was "scooped out".

Ross¹² had a patient with a two year old tumor removed by radical mastectomy. There was evidence of low-grade malignancy in the connective elements but none in the epithelial. Eighteen months later the tumor recurred locally and through the chest wall into the mediastinum. After removal it recurred again in 4 months. The growth was at first encapsulated and easily dissected out but at the third and fourth operation, it was an infiltrating mass which could not be completely removed.

The latest interesting recorded case is by Reich¹⁰ from Bellevue Hospital and this concerns the only recorded bilateral malignant cystosarcoma phyllodes. In February 1942, a lump in the left breast enlarged with pregnancy and was excised. Thirteen months later a radical mastectomy was done for the recurrence. In March 1950 a small "adenoma" was removed from the right breast followed in June 1953, after childbirth, by a radical mastectomy for a large tumor. Recurrences were excised in March and August 1955. At death in January 1956, there was widespread intra-abdominal metastasis with one tumor measuring 25 x 20 x 15 cm. The lungs, thyroid, ribs and vertebrae were also involved.

Case Report I

Miss C. C., white, age 58, was seen in my office as a referral from Dr. A. I. Josey. The day before she had noticed an enlargement of her right breast and it had seemed harder than normal. There was no pain, no nipple discharge and no history of breast tumors in her family. The right breast was considerably larger than the left (which was normal throughout) and contained a hard non-tender tumor at least 4 inches in diameter which was unattached to the skin and freely movable. The nipple was normal and there were no palpable axillary lymph nodes. In 1952 I had locally excised a "papillary type adenocarcinoma" of the posterior vaginal wall at the hymenal ring. There has been no apparent recurrence of this lesion. In 1952, she had an acutely suppurative appendix removed. She was a highly intelligent secretary spinster but admitted that she seldom examined her own breasts. Her health was apparently good and she was literally amazed at what was told her about the size of the tumor.

She was admitted to the Columbia Hospital on

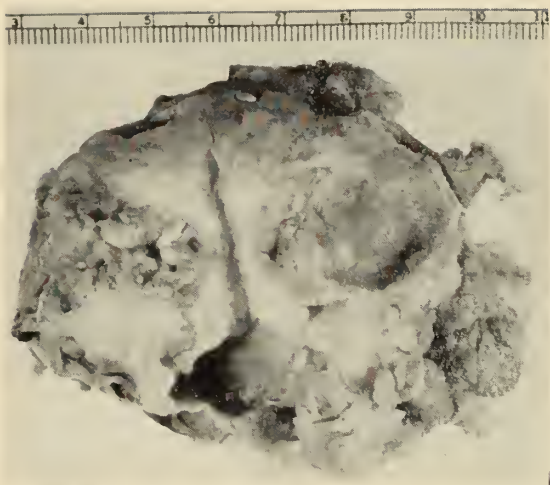


Figure 1

Showing the size and cut surface of the mass with large cystic spaces and finger-like projections found throughout. The word "phyllodes" meaning "leaf-like" comes from these projections.

February 2, 1958 for removal of the tumor and I frankly did not know its nature although I felt it was not malignant. Her studies (including a chest x-ray film) were perfectly normal and at operation the tumor was excised locally and examined by Dr. DuBose Dent. He immediately diagnosed the lesion grossly, and confirmed it by frozen section as "cysto-sarcoma phyllodes". His advice was to do a simple mastectomy and this was accomplished without difficulty or complication. Paraffin sections confirmed the diagnosis and blocks were ordered sent to Dr. Pratt-Thomas at the Medical College of South Carolina and Dr. Fred Stewart of New York City. Both pathologists agreed with Dr. Dent's opinion as to diagnosis and correct surgical procedure.

The tumor measured 11 cm. in its greatest diameter

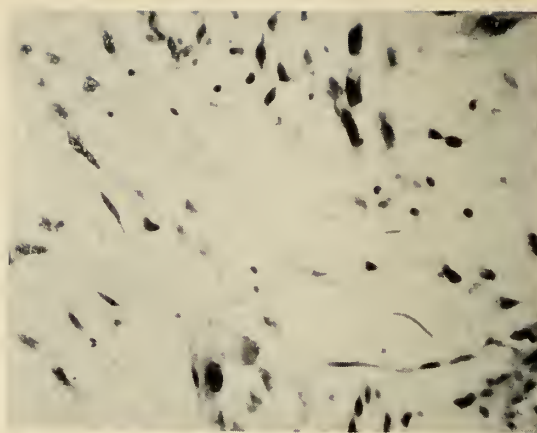


Figure IV

II. & E. Stain, 400X. A view to show the tumor giant cells and large spindle cells in the sarcoma.

and was as described by Müller in 1838. For some unknown reason, it was not weighed. There was complete agreement on the low-grade malignancy of the connective tissue stroma and no evidence of malignancy in the epithelial components. To date, there has been no recurrence and the patient is apparently healthy.

Case Report II

Mrs. S. McC., age 68, white, was admitted to the Baptist Hospital on October 23, 1958 as a patient of Dr. Charles Crews to whom I am indebted for allowing me to add this case to mine.

The patient had noticed a small, hard mass in the upper, outer quadrant of the left breast about one month before admission. It had not been tender or painful but after being in the hospital it had become tender and painful. The mass felt to be about 3 to 4 cm. in diameter, freely movable and unattached to the skin. The nipple was normal and no axillary lymph

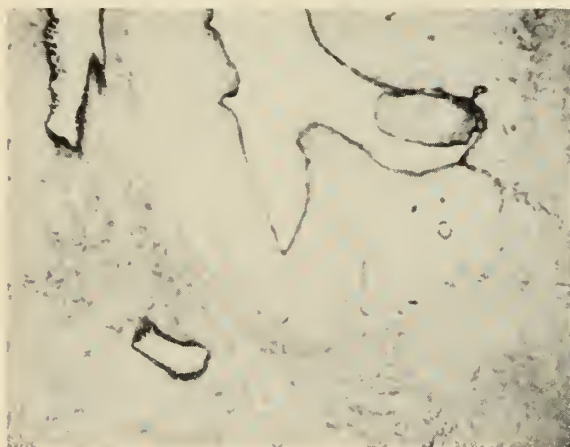


Figure II

II. & E. Stain, 50X. Note the dilated ducts and the close proximity of the sarcomatous component.

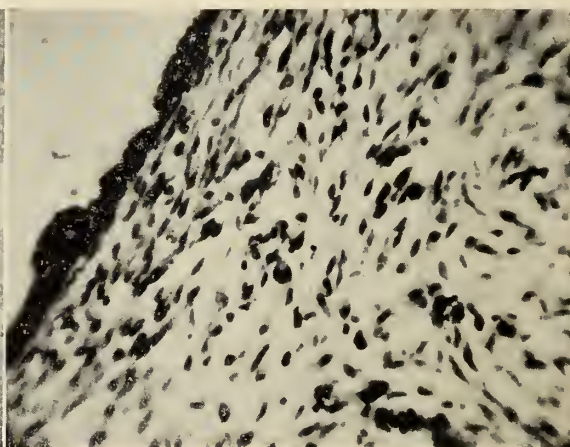


Figure III

II. & E. Stain, 400X. Note the normal epithelial lining of the duct resting upon sarcoma.

nodes were palpable. She had had a hysterectomy for fibroids about 20 years before this and was otherwise in good health. Her studies were within normal limits. The mass was excised by Dr. Crews and the frozen sections were diagnosed as a fibroadenoma. Paraffin sections, however, revealed a cystosarcoma phyllodes and on October 28, 1958 a simple mastectomy was done. The mass was 3 cm. in diameter and was typically that of cystosarcoma phyllodes without malignant change in the epithelial elements. The patient has had no recurrence to this date (November 1959).

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MANAGEMENT OF BRILL-SYMMERS' DISEASE THROUGH CHEMOTHERAPY

JOHN R. SAMPEY, Ph.D.

GREENVILLE, S. C.*

Brill-Symmers' disease, or giant follicle lymphoma, is a malignant tumor which is responsive to chemotherapy. The 109 cases reviewed in this study from the literature of the last decade are too limited in number for generalizations, but they do indicate that this neoplasm is subject to management with chemicals which have been useful in other malignant lymphomas and reticulosos. Nitrogen mustards have been the most frequently employed chemicals in the therapy of acute leukemia,²⁸ Hodgkin's disease,²⁷ lymphosarcoma,²⁵ reticulum cell sarcoma,²⁶ mycosis fungoides,²⁴ and Brill-Symmers' disease. Radioactive phosphorus holds second place in the therapy of chronic myelocytic leukemia,²² chronic granulocytic leukemia,²³ acute leukemia,²⁸ and Brill-Symmers' disease, and adrenal steroids are the third most used

chemicals in the control of lymphosarcoma,²⁵ reticulum cell sarcoma,²⁶ and Brill-Symmers' disease. Antibiotic and triethylene melamine also play a dominant role in the treatment of all the above malignant blood diseases.

Nitrogen Mustards

Sixty-three patients with Brill-Symmers' disease in this study were treated with N-mustards. Sellei and Eckhardt³⁰ employed BCM (1, 6-bis (2-chloroethylamine)-1, 6-deoxy-D-mannitol dihydrochloride) to induce remissions ranging from two to 24 months in 7 of 9 giant follicular lymphomas. Szentklaray³¹ described 5 good and one fair objective response and 6 good and one fair subjective improvement in 8 patients on degranol, and Barlow, et al.,¹ noted one complete and one partial remission in two cases with this N-mustard, but they reported severe bone damage and digestive tract upset with the drug. Rider

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and Warwick¹⁸ tested two aromatic N-mustards on 14 patients: only one of 8 patients given R48, (N, N-di-2'-chloroethyl-2'-naphthylamine), had a remission of several months, and no response was seen in 6 cases treated with R151, (N, N-bis (2-chloropropyl)-naphthylamine).

Windeyer³³ observed some remission in 16 patients with a combination of x-rays and HN2, (dichloroethylamine), and Hall and Olson⁷ reported remissions in three of four patients on the same combination therapy. Cocci⁵ employed x-rays and N-mustard in three Brill-Symmers' cases for a fair response, while Wöckel and Schreiber³⁴ had a good response in one patient treated with x-rays and HN3, (trichloroethylamine), but a second patient died of hemorrhage under the therapy. Rollins and Shaw²⁰ and Hochman and Ickowicz⁹ observed good clinical response in single cases of giant follicle lymphomas, following the administration of ACTH and N-mustard, and cortisone and N-mustard, respectively. Bohnel and Stacher⁴ employed x-rays, N-mustard, TEM, and sanamycin to obtain good remissions in three patients.

Adrenal Steroids

These hormones rank next to N-mustards in the number of studies which have been conducted on the control of Brill-Symmers' tumors. Marchal, et al,¹³ reported the best results in patients with B-S disease of any patients with malignant blood diseases who were treated with ACTH and cortisone; in testing 80 patients (30 cases of leukemia, 35 of Hodgkin's disease, etc.) they noted the best regressions in two cases of giant follicle lymphoma. Meduri and Notario¹⁴ found ATP (adenosinetriphosphoric acid) therapy alone ineffective in two patients with B-S disease, and three with Hodgkin's disease, but associated with TEM or prednisone there was clinical improvement and less toxicity in all five cases treated. Scafì and Martinelli²⁹ found no symptoms of the disease for seven months after placing one patient on prednisone, and Ricci and Querirolo¹⁷ described a long remission in another patient on this hormone. Hill, et al,⁸ recorded a partial response after massive therapy with prednisone and prednisolone in one patient. Attention has already

been called to the results of combination therapy with N-mustards and corticosteroids.⁹

Triethylene Melamine

Beizer, et al,² observed a good clinical response in one of two patients with B-S disease after TEM therapy, and Blackburn and King³ judged the improvement in one advanced case worthwhile. Krückemeyer and Riegel¹¹ noted the similarity in action of TEM and x-rays in another case. Comments have been made on the study of Bohnel and Stacher⁴ with TEM in B-S tumors.

Antibiotics

Riegel and Krückemeyer¹⁹ reported a fair response in three patients with B-S disease therapy with sanamycin, and Kabisch¹⁰ noted palliation in three cases on x-rays and the same antibiotic. Ravina¹⁶ induced a good remission with actinomycin C, and Olmer¹⁵ classed his response as fair hematologically and clinically in this antibiotic. The results of Bohnel and Stacher⁴ with sanamycin have been noted.

Radioactive Isotopes

Lawrence and Donald¹² induced three excellent remissions to 20 months in 16 patients with B-S disease after P³² therapy, and they rated three other responses as good, and three as fair. Desgrez, et al,⁶ noted some improvement in two cases following the use of radio-phosphorus or x-rays. Werff and Haanen³² found radiobismuth produced complete remissions in two patients, but that three far advanced cases failed to respond.

Summary

Table I summarizes the management of Brill-Symmers' disease through chemotherapy. The good remissions of column 3 range from

TABLE I
Control of Brill-Symmers' Disease Through Chemotherapy.

Chemicals	No. of Cases	Good Remissions	Fair Remissions
N-mustards	63	12	16
Radioisotopes	23	8	5
Adrenal steroids	11	4	7
Antibiotics	8	1	7
TEM	4	--	3

complete absence of clinical symptoms of the disease and normal blood pictures to marked improvement clinically or hematologically for periods ranging from weeks to months. The

showing of 12 good and 16 fair responses in 63 patients treated with N-mustards is better than that indicated, for Windeyer³³ failed to record the number responding in 16 cases. Four chemicals widely used in the control of malignant blood diseases,²² namely, myleran, folic acid antagonists, colchicines, and urethan,

apparently have not been given clinical trials in Brill-Symmers' disease.

Acknowledgments. The original literature has been made available by the National Library of Medicine, and the libraries of Furman University and Greenville General Hospital.

A list of references may be obtained from the author.

MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

Primary pulmonary hypertension

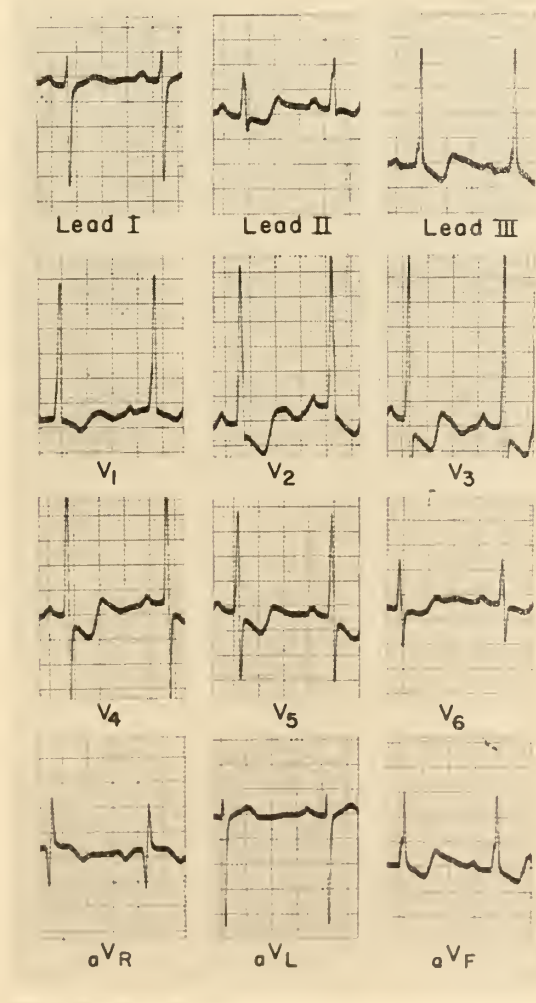
DALE GROOM, M. D.
Dept. of Medicine

Case Record—The finding of a high pressure in the pulmonary artery without evidence of any cardiac or pulmonary pathology to which it could be ascribed was the basis for the diagnosis of primary pulmonary hypertension in this patient. Her history was one of a normal birth and development but conspicuously poor physical endurance since early childhood. By adolescence she had experienced orthopnea and disabling exertional dyspnea, only partially relieved by digitalis, and there were said to have been several instances of unexplained syncope and at least one of hemoptysis. While still in her teens she began complaining of intermittent pain in the substernal area with radiation into the axillae and down both arms.

Pertinent physical findings were a greatly accentuated second heart sound at the pulmonic area with a systolic murmur of moderate intensity along the upper left sternal border, and a forceful thrust felt over the precordium on systole. The systemic blood pressure was normal. There was no cyanosis at rest, no clubbing or polycythemia.

Special diagnostic studies carried out at various times on this patient included angiocardiography, aortography and three cardiac catheterizations. All failed to disclose any intra- or extracardiac shunt. Pressures recorded in her pulmonary artery (which was grossly enlarged, as was the right ventricle) ranged from 105 to 150 mm. of mercury systolic, 70 to 75 diastolic. Her arterial oxygen saturation which had been reported as 95% at age 16 had dropped to 84% at age 20 when this electrocardiogram was made.

Electrocardiogram—The right axis deviation is commensurate with the very high R waves in the right precordial leads which show delayed intrinsicoid deflections (approximately 0.04 sec. after onset of the



QRS). Also in these leads the S-T segments are depressed up to 3 mm. and the T waves inverted. The actual Q-T interval is probably within the normal range for this heart rate of 80 in a woman though it

may appear prolonged in places, perhaps due to accentuation of U waves.

At the far left precordium the potentials are relatively small. The QRS of V_6 looks like a normal "transition zone" complex such as is usually seen in the V_3 or V_4 positions, its displacement toward the left generally being indicative of a clockwise rotation of the heart as viewed from below.

In some leads the QRS complexes are slurred or notched but their width is consistently less than 0.08. No signs of atrial hypertrophy can be seen in the P waves which are normal throughout.

Discussion—This electrocardiogram illustrates an advanced degree of hypertrophy involving selectively the right ventricle. The mounting overload or "strain" imposed on that chamber is signified by the S-T depressions and T wave inversions which, though they may be exaggerated by digitalis, became more prominent as the patient's cardiac reserve declined. Her entire clinical picture is consistent with the pressures of five to six times normal which were demonstrated in the right ventricle and pulmonary artery by cardiac catheterization.

Usually hypertension in the pulmonary (arterial) circulation is secondary to some intrinsic pulmonary disease such as emphysema, fibrosis or pulmonary emboli, or to an abnormal shunt of blood from the left to the right side of the heart (e.g., septal defects, patent ductus arteriosus). Stenotic obstruction of the pulmonary outflow tract of course raises the intraventricular pressure but does not permit its transmission into the pulmonary artery, thus subduing rather than intensifying the pulmonic second heart sound. Distinguished from these secondary types is

the category of primary pulmonary hypertension for which there is no demonstrable cause. In all types the pressure in the pulmonary circulation can equal or even exceed that on the systemic side.

Primary pulmonary hypertension is a rare disease characterized clinically by progressive enlargement and failure of the right ventricle, often with syncope and anginal type pain, ultimately cyanosis and early death. It is found chiefly in young adults and, as its name implies, the etiology is unknown. Extensive vascular changes found in the lungs at autopsy—narrowing and sclerosis of the pulmonary arterioles, analogous to that of essential hypertension—have led to the view that the elevation of pressure is a consequence of the increased resistance offered by narrowed arterioles, hence not actually the primary factor. However, cases with minimal arteriolar abnormality have been cited in support of the opposite view, that it is the pressure elevation which occurs first, followed in time by irreversible vascular changes. A division of primary pulmonary hypertension into two types, those cases with and those without arteriolar sclerosis, has been advocated on pathologic grounds, but the major consideration from the clinical standpoint is the differentiation from them of patients in whom the elevation of pressure in the pulmonary circulation is secondary to a shunt or some other lesion, potentially subject to correction.

Electrocardiograms showing such an extreme degree of right ventricular hypertrophy are much more typical of congenital than acquired lesions. Both the history and ECG of this patient suggest that her disease, if not congenital, was present during the early developmental years.

Coronary and aortic atherosclerosis in the Negroes of Haiti and the United States. Dale Groom, M.D., F.A.C.P., E. E. McKee, M.D., Charles Webb, M.D., Faye W. Grant, Ph.D., Charleston, Vergniaud Pean, M. D., Edith Hudicourt, M.D., Port-au-Prince, Haiti, and James Dallemand, M.S., Detroit, Michigan. *Ann. Int. Med.* 51:270—August 1959.

The degree of coronary and aortic atherosclerosis in 267 autopsies of Haitian and American Negroes was graded on a scale of 0 to 4 by the same pathologist, their individual age, sex and country of origin unknown to him. Routine autopsies, covering all types of mortality over age 20, were utilized as representative samples of the two population groups.

Hearts of the American subjects averaged almost double the degree of atherosclerosis in the coronary arteries, whereas no such difference was observed in the corresponding aortas. This held true for both

males and females, and at virtually all age levels. Coronary grades of male subjects from both countries increase similarly with age to a semblance of a plateau in the 40's; those of the females showed a remarkably uniform ascent from the lowest values to the highest at 60 and beyond.

Vital statistics proved to be a remarkably inaccurate index for comparing the incidence of coronary disease in such contrasting civilizations.

The apparent predisposition of the American group to coronary but not to aortic atherosclerosis—a highly significant difference statistically—suggests the importance of factors other than diet in the etiology of coronary disease. Conceivably, these factors may include the more stressful environment, and the greater complexity, mechanization, education and competitiveness of the Negro's life in the United States.

THE GREENVILLE COUNTY MEDICAL SOCIETY HISTORICAL SKETCHES CRISIS AND REACTION

J. DECHERD GUESS, M. D.

This is the eighth of a series of articles, adapted from the book *A Medical History of Greenville, South Carolina*, written by the same author, and which was published by the Greenville County Medical Society in 1959.

The year 1937 was one of ferment and change in organized medicine in South Carolina. The movement began in Columbia, and spread to several of the larger societies. These societies became foci of helpful influence. All doctors in the surrounding areas were invited to share equally with their own members all the stimulation and instruction which became available.

The movement had three interrelated features. These were the publication of a monthly society bulletin, a reception and dutch supper each month, and a monthly program of seminar quality with a speaker of national reputation.

The Recorder was the name given to the Columbia Society bulletin. Its first number contained the following:

"In furtherance of its progressive policies, the Columbia Medical Society wishes to announce a departure from the . . . program which has heretofore characterized its meetings . . . Our meetings will be signalized by addresses from physicians of national reputation . . . Another new feature will be the issue of a monthly publication . . . which will serve as a repository of the society for the information of absent members . . ."

Many Greenville doctors began attending the meetings of the Columbia Society more or less regularly. They liked the meetings, and they liked *The Recorder*.

When Dr. W. Thomas Brockman was elected president of the Greenville County Society for 1938, he immediately suggested that the Society follow the leadership of Columbia. His suggestion was enthusiastically adopted. Volume I, Number 1, of *The Bulletin* of the Greenville County Medical Society was in the mails a few days before the date of the February meeting. It was sent to all South

Carolina doctors and to doctors in bordering counties of Georgia and North Carolina.

The leading article in *The Bulletin* that first month was a signed article by President Brockman. He said:

"The year of 1938 started off with a bang for the Greenville County Medical Society. It was the almost unanimous opinion at our first meeting on the night of January 3rd, that we must embark on a more ambitious Society program. It was obvious that the time was ripe to begin a monthly bulletin and for a more ambitious scientific program each month. Along with these, a movement was begun towards ultimately securing for ourselves a home, a permanent place of meeting, or an Academy of Medicine, if you like, where we can meet in comfort and have such facilities as a library, an amphitheater, a dining room, a gymnasium, a lounging room, etc. Such a home will tend to unite us more closely.

"There is a need for more unity in medicine. Is it safe and sane that we coast along while all about us merchants, labor, industry, and business are becoming more united? Are we safe to stand by, poorly organized, and watch our inherited rights as physicians, and guardians of public health gradually being trampled upon? No! We need all of these and more to withstand the inroads that all of us have felt in recent years are being made upon us. We are not a vital influence as an organization locally. We need this better organization socially, we need it scientifically, and economically.

"Greenville is geographically the center of the Piedmont section of South Carolina and parts of North Carolina and Georgia are close enough to unite with us in our efforts to have outstanding men come and address us on occasions. I am confident that our neighboring county societies will gladly join us in an effort to make all of us better doctors. The paved highways make it practicable for us to meet together each month throughout the year.

"As President of the Greenville County Medical Society I earnestly beg you to join us in this forward step. Members of neighboring county societies are extended a hearty invitation to meet with us."

Proposals had been discussed and tentative plans had been made at the January meeting. That meeting was graphically described in an editorial in the first number of *The Bulletin*. The editor wrote:

"A crisis occurred in the life of the Greenville County Medical Society on January 3, 1938. This crisis really had its beginning at the December meeting of the society when officers for the ensuing year were elected. Dr. W. Thomas Brockman, in his inaugural address, proposed certain progressive reforms which he hoped would come about in 1938. His remarks served to set the members to thinking. They came to realize that things had gotten into a rut, and that interest in the society meetings was lagging.

"This thinking found expression in the January meeting and when started, the expressions, proposals, and plans came fast. Dr. George R. Wilkinson started things off. He proposed that the society undertake the publication of a monthly bulletin and that the bulletin be sent not only to the members, but to doctors in the surrounding counties.

"The general discussion which this proposal aroused naturally led to a suggestion made by Dr. W. S. Judy, namely: that revival of interest and enthusiasm created by a well-edited bulletin should give rise to a better type of program, one that, while not neglecting the training of local doctors in the preparation and presentation of papers should provide instruction of postgraduate caliber. He suggested that leaders in the various fields of medicine be invited to address the society from month to month, and that doctors from the surrounding counties be invited regularly to these meetings. Dr. Judy's suggestion aroused a hearty response.

"This suggestion led to another. Dr. Hugh Smith asked where the society would hold such meetings as were proposed? He called attention to the fact that since its beginning the society had moved from pillar to post, and that the nurses' lecture room where the meet-

ings are now held is overcrowded when there is a full attendance of the members. He proposed that the society take steps looking forward to the building of a permanent home, with a large and properly equipped auditorium. Enthusiasm was already aroused. It would have been a good time to start a subscription list, but instead words and suggestions as to methods of approach were freely given, and ardor did not cool until the treasurer, Dr. Jack Jervey, suggested that proposals under discussion would necessitate an increase in yearly dues. He mentioned that the county society dues were only \$8.00, and that the state dues had been raised to \$6.00.

"After much discussion a practical enthusiast moved that a committee, to consist of the four officers of the society, ex-officio, and five others be appointed by the chair; that the committee be authorized to study the various suggestions discussed, and that it be given executive power to put into operation such of them as were deemed practicable. The motion passed without a dissenting vote.

"The chair appointed Drs. B. C. Bishop, George R. Wilkinson, W. S. Fewell, Hugh Smith, and J. Decherd Guess to serve on this committee.

"Dr. Brockman called this committee together on January 17. Various details were discussed and a program of progress was launched. This month *The Bulletin* makes its initial bow as a result of that meeting. The editor-in-chief and the publication committee were selected and were instructed to get the first number into the mails before the February meeting.

"The matter of a home for the society will have to wait until a later time. The committee plans a survey of the matter during the spring and summer and expects to be able to offer a concrete proposal in the early autumn."

It was also at the January meeting that a postgraduate type of program was inaugurated. Dr. John F. Rainey was the speaker.

Dr. Rainey was then an associate of Dr. George Wilkinson. He later moved to Anderson, where he has enjoyed a large practice in internal medicine. His subject was "Congestive Heart Failure." The fact that he was a local doctor in no way detracted from the

quality of his address. He spoke with skill and assurance, and amply demonstrated that distant medical educators need not necessarily surpass those nearer home.

The March meeting was a symposium on obstetrics. It was a joint project of the county society and the State Committee on Maternal Welfare. The late silver-tongued Oren Moore of Charlotte, Dr. Robert W. Ball of the Maternal and Child Health Division of the State Board of Health, and Dr. Harold M. Allison of Greenville were the speakers.

Dr. J. K. Hall of Richmond spoke at the April meeting. Dr. Hall was a brilliant psychiatrist and a very entertaining speaker. His subject was: "Can Professional Individualism Survive in Medicine."

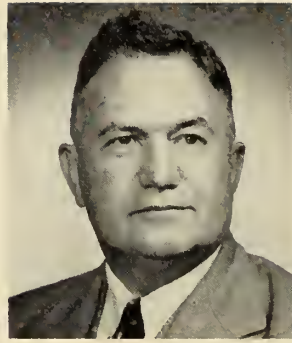
By mid-summer, the membership of the society was rapidly nearing 100. By autumn, a committee of Greenville doctors and other public spirited citizens were working to organize South Carolina's first Blue Cross Hospital Care Plan. Drs. C. C. Ariail, J. L. Anderson, C. O. Bates, T. B. Reaves, and George R. Wilkinson were active on the committee. Dr. C. C. Ariail served as secretary of the organization for many years. The plan was limited in operation to Greenville County. It was unique in that it was the first plan in the country to base its hospital benefits on ward accommodations.

Dr. Poole resigned the editorship of *The Bulletin* at the end of 1939. Under his guidance, it had become well established and its value thoroughly recognized. The entire program initiated at that January meeting in 1938 was still moving in high gear. The society meetings were well attended. Men from

neighboring counties attended regularly. No difficulty had been experienced in securing outstanding medical educators to appear on the society programs. Society members were learning by listening. Unfortunately, difficulty was encountered in including in the programs, well prepared papers by local doctors. In that respect, the Greenville society failed to follow successfully the pattern set by the Columbia society.

It has been twenty years since new life was pumped into the Greenville County Society by Tom Brockman and his colleagues. The success of the Columbia society's effort had acted as a fine example and a strong incentive to the Greenville group. *The Bulletin* has never missed publication on time. The character and quality of the scientific programs have been sustained. As the society has grown in members, the actual number of members attending the meetings has increased. Percentage wise, based on total membership, the attendance seems not to have been so good, perhaps.

There has become evident a certain restlessness and dissatisfaction with the meeting place and the quality of the meals. Unfortunately, a society home which had been so enthusiastically visualized in 1939, is far from a reality. Gifts to help make it so are neither so generous nor so frequent as they were at first. Doctors are still prosperous and they are still generous. But calls have increased, homes had to be provided, living costs are higher, and many new offices have been built and equipped. One cannot finance a medical foundation under the G. I. bill nor can it prosper under a twenty or thirty year plan.



PRESIDENT'S PAGE

I wish to remind you delegates who voted to meet at Myrtle Beach this year, that it is important to support your organization in person. It is imperative that you attend the meeting with your presence at the scientific session.

The Program Committee consisting of Dr. William H. Prioleau, Chairman, Dr. Dale Groom and Dr. George Durst, have put forth much time and effort in securing excellent men in medicine to conduct our meeting. It is your duty to participate and show your interest by giving them your attention. You being there are the ones to benefit as we are receiving the instructions and the knowledge of these experts. You stand to improve your methods in treating your patients and give them better and more discreet treatment.

Make your reservations early at the headquarters hotel, The Ocean Forest Hotel, as there is a real treat in store for you as the President-elect of the American Medical Association, Dr. Vincent Askey, will address us on Thursday evening, May 19th. The dessert for the banquet that evening is a talk from the Honorable James F. Byrnes who is the greatest statesman South Carolina ever produced. These messages you cannot afford to miss.

William Weston, Jr., M.D.
President

Editorials

RE: CRITICISM OF DOCTORS

Much is being said and written about changes which have occurred in the attitudes of the public toward doctors. It seems that this "bear baiting" of doctors, as it were, is more prevalent among laymen and lay writers than it is among doctors. It seems to have become rather fashionable for writers, professional "do gooders" and politicians to take a dig at doctors and at medical organizations with slight or even no provocation. As is so frequently stated even by unfriendly critics, it is doctors in the mass who are the subject of criticism, and not individual practitioners.

There are two good reasons for this. "My doctor" implies a highly personal relationship between an individual and an individual doctor. There is no organization of the admirers of any given doctor, and therefore no mouth-piece for the affection and respect felt for him.

There are relatively few of these "beloved physicians," they are themselves not organized, and so they do not create mass opinion.

The great group of present day physicians, regardless of their many good attributes, are not "beloved physicians," and they collectively are responsible for mass attitudes toward the profession. The most that can be said for them is that they are skillful, or thorough. Rarely is it said of them that they are kindly, or that they come night or day when called, or that they stayed at the bedside all night long.

Perhaps, it is difficult to love a man who lives in a so much better home than you do, who drives a so much more expensive car, whose wife dresses so much better than your wife does, and who hesitates about paying a call at night or "after hours" or on Saturdays and Sundays, and who sends you a bill promptly and writes you a letter or calls you on the phone if you allow your account to become as he terms it "delinquent."

Perhaps, it is difficult to love a doctor who advises admission to hospital for what seems to you to be a minor illness, and then spends your money as freely as water in having done

many x-ray and other diagnostic examinations, while he pursues the game of treating "the man instead of the disease" or of treating the "whole man." It is not so bad when an insurance company pays the entire bill. It becomes outrageous when it refuses to pay for diagnostic surveys. Then, perhaps, one wonders at the physician's zeal and questions his good faith—unless the patient and the doctor are in such complete rapport that the doctor is his "beloved physician."

Perhaps, we doctors do not realize how much criticism is directed at doctors from within the profession. It is considerable, and it is harsh. It should command study by medical faculties. It should be recognized by the profession.

Recently, the writer planned an article dealing critically with the trends in medical practice. The article was already mapped out, when he looked through two current journals and found four articles dealing with the same subject. So much of what was said by the authors was so nearly like what he had intended to say, that he had to replan his article, so as to give credit to the other authors for what he was about to say as original thought.

The author's article will be published in *The Journal*. Its thesis will be denied by many readers. Those who are tempted to criticize it too harshly might bear in mind that in effect, it is a collaboration by four observers of modern medical practice.

J. Decherd Guess, M. D.

JOURNALS WITHOUT END

To introduce a new Journal by bemoaning the great multiplicity of medical journals is probably not a very politic approach. Some day some solution will be reached toward making information available in a less elaborate way.

A new journal to be published by C. V. Mosby Company called *Clinical Pharmacology and Therapeutics* is announced for January, and is no doubt, barring the usual delays of

printers and editors, now to be had. This is described as a clinical discussion of pharmacology and therapeutics and aims to bring together and winnow and condense the immense amount of information which is scattered throughout many journals and countries. It has a list of able members of the editorial board, and promises to be a useful production. Being the official publication of the American Therapeutic Society it should contain authentic and usable material.

PUBLIC RELATIONS BEGIN OR END AT HOME

The other day one of our colleagues told us about an experience which one of his patients had recently had. She had called him in tears to protest humbly against an experience which she had just been through. It seems that her child was ill, and instead of calling her usual doctor, since he lived at some distance, she had called one of the doctors in her immediate neighborhood. The doctor had made no protest about coming, but apparently on his way he had worked himself into some sort of stew, and came storming into the house complaining about being called out—it was not late at night—and being worked so hard that he thought he would not survive. He went quickly over the sick child, administered penicillin, said a very few words, and took himself off grumbling about the situation. From all accounts, the mother had been neither demanding nor urgent. Perhaps her impression of the doctor's manner and approach had been somewhat exaggerated, but even so, the incident was enough to send her into tears and reproaches.

Let us hope that whatever animus she might have developed against this particular doctor will not be carried over to the whole profession. Fortunately, she is a reasonable person, but not every patient is. One is led to wonder what the organized efforts of the profession to maintain agreeable public relations can accomplish in the face of many incidents of this kind.

FUND RAISERS

Almost every disease has an organization whose aim is to investigate and eradicate it if

possible. Many of these societies have taken pains to justify the effort by proving the need for it, and have secured the endorsement of medical people who are capable of passing judgment on the value of the activities. Some of them have not bothered to do more than set themselves up and go to work without showing that their effort is not duplicating that of other groups, and some of them have done very little that can be seen with the money which has been raised for their special objectives. The tendency is for those people who are active in the effort, and especially those who have to contend in their families with conditions which they recognize as serious and difficult to proceed on a sort of blind approach to a problem which they do not see in its larger connotations. The older and well recognized organizations make available to those who are interested statements as to their methods, objectives and expenditures, and seek endorsement from professional bodies. Their names are familiar to all of us.

For some years a relatively new society which has interested itself in the problem of cerebral palsy has been carrying on a campaign in South Carolina for raising funds, predicated its effort on the statement that the problem of cerebral palsy is not cared for sufficiently by existing organizations. There has been no effort to secure endorsement by organized medical groups, and it has been difficult to see where the funds have been expended and what the results are. Lately the efforts of this body have become much more vigorous, and drives have been set up in various parts of the state without regard to local opinion and without full explanation of what the purposes are. Certain claims have been made that activities are supported by the money which has been collected, but in more than one instance the claims could not be verified.

It is unfortunate that with the multiplicity of drives there cannot be a better correlation, and a frank realization that it may be possible to dilute the efficacy of all of the activities by bad management and bad approaches to the problems which they seek to solve. Certainly the existence of a need, an honest campaign, and a method of use of funds which is open to

inspection by the public and by the profession are the least necessary requirements for proper recognition and support.

REPORT OF A DELEGATE TO THE CLINICAL MEETING OF THE A. M. A. DALLAS, TEXAS

George Dean Johnson, M. D.

Medicare was discussed by General Wergeland. Utilization was so high at first that restrictions had to be imposed. These restrictions will be lifted in part beginning January 1961. Some of the items to be restored are: (1) Injuries on an outpatient basis; (2) certain surgical hospital cases; (3) emotional disturbances — 21 day limit; (4) uncomplicated optional surgery. The general was high in his praise of the type medical care received by dependents and felt that everyone was well pleased. On or near a military base the commanding officer still has sole discretion as to whether a dependent shall be admitted to a service hospital or go to a private or community hospital or doctor. In roughly three years about two hundred million dollars have been paid out — 51% to physicians and 49% to hospitals. By 1961 it is estimated that 81 million dollars will be necessary.

Several states have a program which is relatively unknown in our state. It is called a public assistance program in California. It is primarily for (1) old age needy, (2) aid to needy blind, (3) aid to needy children. In setting up this program the California Medical Association set up three requirements: (1) Free choice of physician; (2) Blue Shield as the fiscal agent; (3) Home and office care only. There are in California out of about 17 million population 450,000 recipients of this program. 29 million dollars are required to pay for it — with the State and U. S. Government each paying half.

In the first year utilization almost bankrupted the plan with 60% going to drugs. Drugs had to be restricted and only emergency surgery was allowed. The plan is actuarially sound now.

In Florida, the system is different in that all physicians' fees are paid into the State Medical Foundation. Admittance to a hospital is only by approval of a physician.

Illinois has had a program of this type since 1942. This plan furnishes complete medical care to the indigent. A fee schedule was set up and a review committee to pass on over-utilization, over-usage of drugs, over-hospitalization, and over-use of home visits was established in each county. Five years ago direct payment to physicians was started by the Commission for Public Aid and immediately utilization went up. Physicians over the state now receive \$246,000.00 per month and drugs cost \$350,000.00 a month.

In Colorado all pensioners and others receiving state and federal aid are handled through Blue Cross-

Blue Shield. This works to everyone's advantage and may be the answer to the Forand Bill.

The State of Washington has had a working plan since 1934. Each county has a prepaid plan. There are 124,999 out of a population of 2,700,000. There is full and complete medical and dental coverage—necessary or optional. At one point \$60,000.00 per month was being spent on tranquilizers. This had to be cut in half. Ninety percent of physicians participate. Screening is done at the county level. Another control is the budget. If it is exceeded, the fees must be prorated:

Nursing homes get	46%
County hospitals	20.8%
Doctors	12.8%

The committee on amendments to the Constitution and By-Laws made a complete report as regards osteopaths and ownership of pharmacies and stock in pharmaceutical houses. It stated that a medical doctor may teach in an osteopathic school provided that school was changing to a medical school under the direction of the Council on Medical Education and Hospitals. As regards ownership of pharmacies the committee reported a paragraph from the Report of the Judicial Council; "Because of the nature of these practices and because they can vary so greatly, the Council has insisted that it is the obligation of the County Medical Society to insure that no one of its members violates the high ethical tradition of the Medical Profession. It is the obligation of the County Medical Society to investigate complaints against its members and to take appropriate action, when indicated, to protect both the public and the profession." More and more it is realized in the House of Delegates that local breaches of etiquette, or ethics, must be corrected by the local county or sometimes state society.

The Council on Medical Education and Hospitals did its best to dissolve itself as a branch of the House and be under the supervision of the Trustees. The House refused this request. The Trustees took no part because after all it is the executive committee of the House of Delegates.

In the report of the Committee on Reports of Board of Trustees it was announced that Dr. Leonard Larson became Chairman in June, Dr. Julian Price, Vice-Chairman; Dr. Hugh H. Hussey, Secretary; and Dr. Raymond M. McKeown, Treasurer of the Association. The Board is divided into three committees: one on Scientific Activities, one on Socio-Economic Activities; and one on Miscellaneous Activities.

The annual meetings have been approved as follows:

1960	Miami Beach	June 13 - 17
1961	New York	June 26 - 30
1962	Chicago	June 11 - 15.
Clinical		
1960	Washington, D. C.	Nov. 29 - Dec. 2
1961	Denver	Nov. 28 - Dec. 1
1962	Los Angeles	Nov. 26 - 30.

The A. M. A. continues its membership in the Joint Blood Council, Inc.; Joint Commission on Accreditation of Hospitals; Blue Shield Commission; World Medical Association; U. S. Chamber of Commerce; and others.

The Board voted to rejoin the National Health Council as a member.

The A. M. A. has liaison with a great many other medical and surgical as well as other organizations.

The A. M. A. as well as Mr. Sam Rayburn urged doctors not only to visit their legislators but also when they wish to testify to *go in person* and not send someone.

The Committee on Rehabilitation again urged every constituent medical society to form a rehabilitation committee. It has produced a new film "Rehabilitation Adds Life to Years" which had its preview in Dallas during the convention.

Because of the dangers of radiation all constituent societies are urged to approve programs of inspection of all fluoroscopic and radiographic equipment in cooperation with local dental associations and public health departments.

The Reference Committee on Insurance and Medical Service urged that each state association should be encouraged to establish placement services with the A. M. A. acting as a central clearing house.

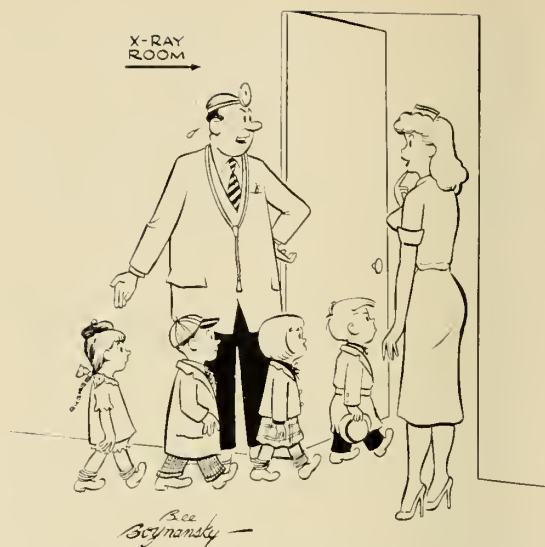
The report of the Committee on Insurance and Prepayment Plans on the growth of the number of persons covered by voluntary health insurance lend strong support to the profession's objection to federal legislation calling for national health insurance coverage for those over 65. Each year this committee has reported substantial increases in those insured. This year the number stands at an all time high of well over 123 million individuals who have hospital insurance, 111,000,000 surgical and 75,000,000 medical.

The statement "let's use, Not abuse" needs widespread publicity, emphasizing that there are others who share the responsibility for the success of voluntary health insurance and prepayment plans.

As far as coverage over 65 years of age, 33 Blue Shield Plans and 62 companies offer plans. Nineteen other Blue Shield plans are in the process of developing coverage. Rhode Island Medical Society Physicians Service has had no age limit in its program for prepaid surgical-medical care since 1950 and it has enrolled nearly 60% of the eligible population of the state over the age of 65.

The Reference Committee urges every doctor to do his utmost to inform the public that veterans' care in veteran hospitals is primarily for service connected disability and not for everyone else in the family especially often when the veteran is well able to pay the cost of hospitalization. This is a constantly recurring item of importance in the House of Delegates.

One resolution which was wholeheartedly endorsed by the House of Delegates dealt with the approval of the Blue Shield concept by the House of Delegates.



"They won't talk—find out which one—swallowed the quarters."

The Reference Committee on Legislation and Public Relations gave out some interesting facts and figures. During the first session of the 86th Congress there were 13,892 bills introduced, 1000 were studied and 495 analyzed. The A. M. A. representatives testified or submitted written testimony in 19 instances. Contrary to frequent criticism the A. M. A. supported 14 of these resolutions. On 4 occasions the statement was for information only and in only one, the Forand Bill, did the A. M. A. actively oppose. People who should know feel that the Keogh Simpson Bill has a good chance to pass in the coming session.

The A. M. A. was against international medical research with the U. S. contributing 50 million dollars.

The A. M. A. endorsed again its stand of 1952 favoring an amendment to the constitution favoring a limit to the taxing power of the federal government.

It is urged that wording be changed which states that the federal government is supplying services when actually the government supplies only money to pay for such services.

The Reference Committee on Medical Education and Hospitals brought up a question of student loans. A representative of the student A. M. A. asked for and was granted an opportunity to speak. He stated that in this day and time engineering firms are offering outright grants to good students and if the A. M. A. hopes to compete for the best students it must set up a scholarship rather than a loan fund. It should be remembered in this connection that already the percentage of "A" students entering medicine has dropped from 40 to 16 percent.

All state societies are urged to encourage and cooperate in setting up courses of study in social, political, and economic aspects of the art and science of medicine for medical students.

The Reference committee on Miscellaneous Business

next brought up the American Medical Education Foundation. Contributions of medical societies and doctors continue to increase in amount as well as number of contributors. The total contributed since 1951 including the first half of 1959 is \$8,028,365 with every year showing an increase. More and more alumni associations are showing an interest in the A. M. E. F. The S. C. Medical College Alumni Association has always cooperated with the A. M. E. F. All money given to the A. M. E. F. goes to medical schools. Not one penny is taken out for overhead.

M. D. should be used after a doctor's name instead of Dr. before.

Dr. Louis Orr, in his address as president, urged all doctors and constituent medical societies to make every effort to recruit outstanding students into the study of medicine.

The most long winded and bitter hassle occurred over the subject of "free choice of physicians." The House of Delegates refuses to state that plans such as the Kaiser Permanente and United Mine Workers are ethical as far as doctors are concerned because they represent a third party between the physician and the patient and in some instances may prevent proper patient choice of physician. However, the A. M. A. goes on to say that the patient has a right to choose between such a plan and the practice of independent medicine on a fee-for-service basis. This will be a continuing argument especially by such states as Kentucky, Ohio, Pennsylvania, West Virginia, Colorado, and California where such plans are in operation. Is a doctor who is employed by these plans more unethical than one who goes into Public Health Service or one who is employed by a Corporation to examine and treat its employees injured while working. Sometimes one gets the impression that the difference is small. I believe that this is an evolutionary matter and will someday receive universal sanction.

Each Constituent Society should:

1. Have an active committee on Rehabilitation.
2. Establish and promote programs of inspection and testing of all fluoroscopic and radiographic equipment. Cooperation with dental associations and departments of public health should be urged.
3. Establish a placement service by each state association in cooperation with the American Medical Association.
4. Study by each state association of the problems involved in financially catastrophic illness with a view to evolving community programs to help finance needed treatment without requiring the normally self supporting patient to go on public assistance rolls. Planning in this area is needed at all levels of medical organization.
5. Organize a medical service committee which is as important at the state as at the national level. (P 258 Handbook House of Delegates Dallas meeting.)
6. (1) To assist actively in obtaining needed care

for those veterans with financially catastrophic disabilities; (2) help veteran patients determine the probable cost of care so that they may more accurately judge their ability to pay, considering the extent of their insurance coverage; (3) establish liaison with Veterans' Administration Hospitals to assist in estimating the cost of private care in order to facilitate the administration of such catastrophic cases; and (4) take such other steps as are advisable locally to assist veterans and their organization in assuring that this care is prepaid for those who need it most.

7. Establish Hometown medical care for veterans where it is not now provided and urge state associations to continue their efforts in the maintenance of free choice of physician for veterans.

8. Establish a single committee of the state association to negotiate with governmental agencies for the private care of patients for whom the government assumes responsibility.

9. Encourage and cooperate in setting up courses of study in social, political, and economic aspects of the art and science of medicine for medical students.

10. Urge the Woman's Auxiliary to expand its activities in the field of national legislation.

11. Use M. D. after a doctor's name instead of Dr. before wherever practicable.

12. Make every effort to recruit outstanding students for the study of medicine.

THE MONTH IN WASHINGTON

Congress appears headed for a showdown this session on legislation for the Federal government to provide medical care for aged persons.

The medical profession and allied groups stepped up their activities in opposition to such legislation as indications mounted that the issue was approaching a crucial stage. Several State Medical Societies planned to send delegations to Washington to personally express their opposition to their Congressmen.

Pressure behind such legislation began to build up early in February.

The Eisenhower Administration announced it was working on three possible programs for providing health care for aged persons in cases of catastrophic—lengthy and costly—illness.

Without amplification, President Eisenhower told a news conference that there was under consideration "a possible change" in the Social Security Act "to run up the taxes by a quarter of a per cent to . . . make greater provision for the care of the aged." The President's statement that "there has been no conclusion reached in the administration" was backed up by Arthur S. Flemming, Secretary of Health, Education and Welfare, in a clarifying announcement.

Flemming said his department was working on two other approaches to what he called a serious problem in addition to the possible revision of the Social Security law mentioned by Mr. Eisenhower. The HEW Secretary said consideration also was being given to: 1) stepped-up Federal assistance under the

Federal-state public assistance program, and 2) the Federal government supplementing voluntary insurance programs.

Flemming again expressed opposition to the Forand bill which would increase Social Security taxes by one quarter of one per cent each on employers and employees to provide hospitalization, surgical benefits and nursing home care for Social Security beneficiaries. The Secretary said he wanted to "underline that the position of the administration is opposition to the Forand bill."

Flemming said he hoped to have an administration bill ready to submit in early April to the House Ways and Means Committee where the Forand bill is pending. The Committee is scheduled to take up in late March or early April proposed changes to the Social Security Act.

Proponents of the Forand bill—which is vigorously opposed by the American Medical Association and allied groups—were pointing their campaign toward securing the House Committee's approval of the legislation at that time.

The AFL-CIO, a main supporter of the Forand bill, urged labor union members to write to congressmen on the Committee urging them to vote for it. The AFL-CIO also distributed a pamphlet quoting a handful of physicians as supporting the legislation. But the labor organization didn't mention that the overwhelming majority of doctors oppose it.

The Senate Subcommittee on Problems of the Aged and Aging, headed by Sen. Pat McNamara (D., Mich.), issued on behalf of its Democratic majority a report stating that use of the Social Security program "is the most efficient procedure for providing" health care for older persons.

The AMA and the Subcommittee's Republican minority promptly disputed this conclusion. An AMA statement issued in Chicago said:

"The American Medical Association today sharply disagreed with the recommendation of the McNamara subcommittee regarding government medicine for Social Security beneficiaries.

"Dr. Louis M. Orr, Orlando, Florida, President of the A. M. A., said:

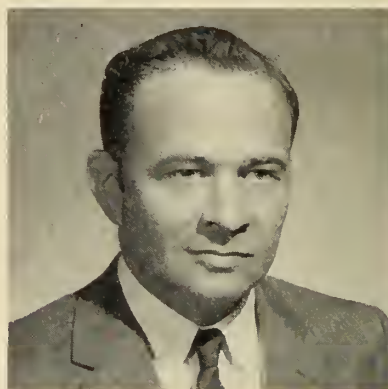
"This is a politically inspired committee. Senator McNamara, Democrat from Michigan, has long supported political medicine. The fact is that at the seven subcommittee hearings held throughout the United States, observers heard little support expressed by the older citizens who attended the hearings for government medicine financed by additional taxes and administered through Social Security."

The Republican minority stated that testimony before the Subcommittee "proves that it is possible for elderly people to secure private insurance to provide hospitalization and surgical benefits without any intervention by public authorities."

Sen. John F. Kennedy (D., Mass.), a leading contender for the Democratic nomination for President, introduced legislation similar to the controversial Forand bill but broader in scope. The Kennedy bill would

eliminate surgical benefits but would add diagnostic outpatient and home nursing services.

NEWS



DR. JERVEY TAKES HELM OF MEDICAL FEDERATION

Dr. Harold E. Jervey, Jr., of Columbia was inaugurated as president of the Federation of State Medical Boards of the United States at the 56th Annual Congress on Medical Education and Licensure which was held in Chicago, Ill., Feb. 6 to 9.

Doctor Jervey is the first person from South Carolina to serve as president of the State Boards. At 38-years-of-age, Doctor Jervey has become one of the youngest doctors to serve as president.

For the past couple of years, Doctor Jervey has served as secretary of the South Carolina Board of Medical Examiners.

In 1953 Doctor Jervey was appointed to the State Board of Medical Examiners. The Board is responsible for approving licenses for doctors to practice, and for enforcing the Medical Practices Act. The Board is composed of eight members who are appointed for four-year terms by the Governor following recommendations by the State Medical Association. The Federation of State Boards which Doctor Jervey heads, is composed of State Board members, deans of all medical colleges and others interested in medical education and licensure.

He holds membership in the Columbia, State and Southern Medical Associations and the American Medical Association. He is a delegate from the South Carolina Chapter of the American Academy of General Practice to the House of Delegates of the American Academy along with Dr. Charlie Wyatt of Greenville.

A native of Charleston, Dr. Jervey entered the Medical College of South Carolina after being released from active duty and was graduated in 1949. He interned at Greenville General Hospital. After completing his internship he returned to Columbia to practice and now has his office at 1515 Bull Street.

DR. GAZES SPEAKS TO GROUP OF NURSES

Dr. Peter Gazes spoke at a meeting of the Alumnae Association of the School of Nursing of the Medical College of South Carolina, February 2nd.

Dr. Gazes spoke on coronary artery disease and fat metabolism.

M. Grayson Evans, M. D. announces the removal of his office from 350 Maybank Highway to 333 Folly Road, Charleston for the practice of general medicine.

MAYO CLINIC PHYSICIAN IS SPEAKER

The guest speaker for the February 8th Scientific Meeting of the Columbia Medical Society was Dr. Edward H. Rynearson, chairman of sections on endocrinology and metabolism, Mayo Clinic.

Dr. Rynearson spoke on the subject "True Hyperinsulinism vs. Functional Hypoglycemia."

The local speaker for the meeting was Dr. George W. Brunson, Columbia radiologist, who spoke on "Some Pitfalls in Diagnostic Radiography."

LEAVES HOSPITAL

Dr. James R. Cain, chief pathologist at Spartanburg General Hospital, will resign effective April 11 to accept a position with a Columbia medical group.

Dr. Cain said he was leaving because of "the advancement and for personal reasons" in that he would be closer to his Charleston home. He added he would accept a partnership which will conduct pathology tests for both the Columbia and the Baptist hospitals there.

DR. A. J. BUIST

Dr. A. J. Buist was re-elected to serve his 13th consecutive year as chairman of the board of directors of Roper Hospital.

Other officers re-elected to one-year terms were Dr. Edward F. Parker, vice chairman, and Dr. R. W. Hanckel, Jr., secretary.

The board re-appointed the following hospital officials for one year: C. A. Robb, administrator, and H. R. Everett, assistant administrator and accountant. Miss Minerva Kozma is acting director of nursing service.

THERAPY GROUP NAMES FIVE ADVISORS

The South Carolina Physical Therapy Association has announced the appointment of five South Carolinians to serve as the advisory committee to the organization.

Dr. Weston Cook of Columbia, Dr. Leslie Meyer and Robert Toomey of Greenville, Dr. Luther Martin of Charleston and Rep. Robert Hemphill of Chester have accepted appointments to the committee.

Dr. Cook, who practices as an orthopedic surgeon, serves as chief of staff of Columbia Hospital and as consultant in orthopedics at The Orthopedic School in Columbia and Ft. Jackson Army Hospital.

Dr. Meyer has engaged in the practice of orthopedic surgery in Greenville since completing the Duke University orthopedic training program. He is now chief of orthopedics at Greenville General Hospital and St. Francis Hospital and assistant chief surgeon at Shriners' Hospital for Crippled Children.

Dr. Toomey has been director of Greenville General Hospital since 1953. Previous to this he was the assistant director and served in administrative capacity in several New York state hospitals.

Dr. Martin, assistant professor of neurosurgery and on the staff at the Medical College of South Carolina, engages in private practice of neurosurgery and is on the staff of Roper Hospital in Charleston.

Rep. Hemphill is serving the Fifth Congressional District of South Carolina as a member of Congress.

In a recent article in *The Florence Morning News*, expansion and improvement in the field of medicine during the 50's was noted. At McLeod Infirmary, a \$350,000 hospital wing with emergency clinic was constructed. Bruce Hospital grew to a 65-bed hospital and the entire building underwent extensive remodeling. For Saunders Memorial Hospital a \$190,000 wing was completed and a 90-car parking lot was built. The hospital is now a 100-bed institution.

Dr. John R. Bruce was quoted in the article as saying: "Florence is recognized as a medical center and will continue to progress in such a manner. For continual development there will be an added need for continual growth and development in each of the hospitals."

At the Coastal Medical Society Meeting on January 21 at St. George, S. C., Dr. Carter Maguire spoke on "Treatment of Facial Injuries".

DOCTORS BUY TRACT FOR MEDICAL OFFICES

The Greenwood Medical Co., Inc., composed of 13 local doctors, has purchased a large tract of land on West Alexander Avenue, near Self Memorial Hospital, and plans for erection of a group of buildings for medical offices.

The tract of 5.38 acres is diagonally across Alexander Avenue from the hospital building and adjoins the western edge of hospital property, a large open area in grass and trees.

Dr. S. C. Baker, Jr., is president of the company, Dr. P. L. Bates, vice president, and Dr. R. M. Christian, secretary and treasurer.

Dr. Joseph I. Waring was elected president of the Carolina Plantation Society. He succeeds John Henry Dick of Dixie Plantation.

Harold W. Moody, M. D. and Lawrence E. Eddleman, M. D. announce the association of William E. Tryon, M. D. at Medical Center Building, No. 4 Catawba Street, Spartanburg.

The South Carolina Medical Association urges you to

FIGHT FOR AND

Send a handwritten letter to your congressmen and any others who may have
a voice or a vote.

WINNSBORO GAINS TWO PHYSICIANS

Two physicians are to locate in Winnsboro.

James M. Jennings, who was graduated from the Medical College of South Carolina, in December, is currently serving as an intern at the Columbia Hospital. He resides here and commutes to his duties in Columbia. He plans to practice here. He was born at Jacksonville, Fla., but later his parents moved here. He is a son of the late Dr. and Mrs. Charles L. Jennings, and is a graduate of The Citadel.

Dr. Allen P. Jeter received his degree in December at Charleston and is an intern at the Columbia Hospital. He was graduated from Clemson College.

DOCTORS TAKE CD COURSE

Two South Carolina doctors attended a Civil Defense course on the management of mass casualties at Brooks Army Medical Center in San Antonio, Tex., beginning February 15.

Taking part in the five-day course were Dr. James Graham Shaw of Columbia and Dr. Charles R. May of Bennettsville.

The Charleston County Medical Society met on February 9, 1960. Dr. Edgar Hull of New Orleans, La. was the guest speaker; his topic was "Medical Shock". Dr. William H. Lee, the local speaker presented a paper "Vasodilator Drugs".

Speaker for the March meeting was Dr. Leroy E. Duncan, Jr. His research studies have included work on aging, congestive heart failure, and atherosclerosis. His talk was on the Mechanism of Development of Experimental Atherosclerosis.

The local essayist was Dr. Vince Mosely who spoke on Amoebiasis.

DR. FREDERICK CHIEF OF STAFF AT HOSPITAL

Dr. Larry Frederick of Rock Hill was elected chief of staff of the York County Hospital in Rock Hill at a recent meeting of the hospital's medical staff.

Dr. George Adickes of Rock Hill was elected vice

chief and Dr. Bob Martin of Fort Mill was named secretary-treasurer.

Dr. Frederick succeeds Dr. Sam Lowe of Rock Hill as chief of staff. Dr. Frederick also will succeed Dr. Lowe on the hospital's building committee.

DOCTOR ELLIOTT OPENS OFFICE FOR GENERAL MEDICINE

Dr. Ronald James Elliott has opened an office at 1412 Bull Street, Columbia, S. C. for the practice of General Medicine.

Dr. Elliott recently completed his internship at the Columbia Hospital.

In December, 1958 he was graduated from the Medical College of South Carolina. While at the Medical College he was a member of Phi Rho Sigma Medical Fraternity.

Dr. Elliott is a native of Columbia. He attended the Columbia City Schools and in June, 1955 was graduated, with honors, from the University of South Carolina with a B. S. Degree in Chemistry. While attending the University he was a member of Alpha Epsilon Delta Pre-Medical Fraternity.

DR. STOKES, MRS. HAY GET CITIZEN AWARDS

Top citizen awards were presented recently to an eye surgeon and housewife whose roles in Florence's community activities won them the city's top recognition.

Recipients of the awards were Dr. J. Howard Stokes, chairman of the Florence County Higher Education Commission, and Mrs. Percy D. Hay, who organized the Florence Junior Garden Club and fostered the city's cultural development through work in a variety of organizations.

The "Man of the Year" and "Woman of the Year" awards, sponsored for the first time this year by Florence Inter-Club Council, were presented by the Rev. Curtis Derrick.

Mrs. Hay's husband, Dr. P. D. Hay, accepted a scroll in behalf of his wife, who was ill. The awards

were made at a meeting of the inter-club council at Sanborn Hotel.

Dr. Stokes was cited for his activities in conducting a successful campaign to raise \$300,000 to obtain a campus for the University of South Carolina at Florence.

In making the award, the Rev. Mr. Derrick, enumerated Dr. Stokes' activities as a member of various organizations including: chairman of the Community Chest, United Fund and polio fund drive, former president of the Florence Community Concert Association, vice chairman of the Florence Salvation Army, a director of the Florence Chamber of Commerce, a member of the State Board of Health and the Florence Kiwanis Club and chief of staff at McLeod Infirmary.

Born in Bamberg County, Dr. Stokes is a graduate of the Medical College of South Carolina, and interned at Roper Hospital, Charleston. He moved to Florence in 1938.

DOCTOR TRIPP JOINS STAFF OF STATE HOSPITAL

Harry D. Tripp, M. D., recently assumed position as assistant chief of the Surgical Service. South Carolina State Hospital, Dr. William S. Hall, hospital superintendent, announced.

A native of Bremen, Indiana, Dr. Tripp received his pre-medical education at the University of Notre Dame, Notre Dame, Indiana, and his M.B. and Medical Degree from the Northwestern University Medical School, Chicago, Illinois. He secured a Masters Degree in Surgery from the University of Pennsylvania in Philadelphia.

After engaging in private practice for several years, Dr. Tripp was on the staff of the Cleveland State Hospital, Cleveland, Ohio, the North Dakota State Hospital, Jamestown, North Dakota, and recently the Florida State Hospital, Chattahoochee, Florida.

Dr. and Mrs. Tripp are residing at 1638 Upland Drive.

Dr. R. Bruce Ford, senior resident in psychiatry at the Medical College of South Carolina, is now acting physician resident at the South Carolina State Hospital under the Hospital's six-months training program in psychiatry.

Dr. Ford is the second physician resident to take part in the program, according to Dr. William S. Hall, hospital superintendent.

Originally from Easley, Dr. Ford graduated from Furman University in Greenville and received his medical degree from the Medical College in Charleston. Immediately after an internship at the Medical Center Hospital there he returned to the Medical College for residency training in psychiatry.

The State Hospital's psychiatric training program was started last January. It is designed to train physicians in psychiatry within the framework of the

Medical College's three-year approved training program, which includes this six months residence training at the State Hospital.

Wallis D. Cone, M. D. announces the removal of his office to 38 E. Calhoun Street, Sumter.

Oscar B. Wilson, M. D. has moved to 343 South High Point Road, Spartanburg.

John M. Rhame, M. D. announces the removal of his office to 38 E. Calhoun Street, Sumter.

MEDICAL COLLEGE GRADUATES MEET

Four members of the Class of 1910 at the Medical College of South Carolina held a reunion at Orangeburg.

Joining in the reunion at Berry's on-the-Hill were Dr. Charles Mobley and Dr. W. L. Heaner of Orangeburg, Dr. H. J. Stuckey of Bamberg and Dr. George A. Hennies of Lake Junaluska, N. C.

HONORED BY PHYSICIANS

The Spartanburg County Medical Association recently named popular Dr. A. S. (Doctor Bill) Pearson of Woodruff as Spartanburg County's "Doctor of the Year."

Dr. Pearson, 60, a general practitioner who is also noted for his knowledge of fox hunting, began his medical practice in Woodruff in June of 1928.

He received the honor at the annual County Medical Association banquet at the Spartanburg Country Club.

The award was presented by Dr. Allan B. Warren, Jr., outgoing president of the medical group.

Dr. Warren cited Dr. Pearson's record as a "fine physician and community leader" and added the Woodruff doctor set an example for others in his profession to follow.

Dr. Pearson is a graduate of the Medical College of South Carolina.

His internship was served at Roper Hospital in Charleston, at Mary Black Hospital and General Hospital in Spartanburg.

The popular Woodruff physician is also noted for his gardening ability and his camellias are especially well-known.

A native of Woodruff, Dr. Pearson is now practicing medicine with Dr. Lewis Barnett, Jr. at the medical center on E. Georgia Street in Woodruff.

The award is made by the County Medical Association each year. Only those doctors with general practice can qualify.

DR. THOMAS E. EDWARDS JOINS HOPKINS, WESTON

Theodore J. Hopkins, M. D. and C. Tucker Weston, M. D. have announced the association of Thomas E. Edwards, M. D. beginning January, for the practice

of Orthopedic Surgery at 1410 Barnwell Street, Columbia.

Dr. Edwards is a native of Huntingdon, Tenn. and took his premedical training at Memphis State University. He was graduated from the University of Tennessee College of Medicine, Memphis, Tennessee in 1946.

After graduation, Dr. Edwards served his internship at the Jefferson-Hillman Hospital in Birmingham, Alabama after which time he spent two years as a Captain and Flight Surgeon in the United States Air Force. While in the Air Force, Dr. Edwards served in the European Theatre of operations and on the Berlin Air Lift.

After leaving military service, Dr. Edwards served in a mixed type of residency at the Spartanburg General Hospital after which time he practiced general medicine for several years before coming to Columbia.

Dr. Edwards recently completed his orthopedic training at the Columbia Hospital where for the past year, he has served as Senior Orthopedic Resident and Chief Resident of that hospital.

S. C. LEGISLATURE ACCEPTS BANQUET, VISIT INVITATIONS

It was invitation-accepting day in the general assembly.

The lawmakers accepted invitations to visit the State Medical College facilities in Charleston in February.

The Charleston visit, tentatively set either for February 3 or 10, was the first the lawmakers have made to the multi-million dollar facility in three years.

DR. HARRISON OPENS OFFICE WITH TALBERT

Dr. A. Frank Harrison, III, has announced the opening of his office in association with Dr. Thomas W. Talbert at 1707 Brabham Avenue, Columbia for the practice of general medicine.

Dr. Harrison entered the United States Navy in July 1948, serving in the United States Naval Hospital Corps. In 1951 and 1952 he served aboard the heavy Cruiser U.S.S. Rochester in the Far Eastern waters.

Dr. Harrison received his premedical education at the University of South Carolina, graduating with a B.S. degree in Chemistry in August 1955. He attended the Medical College of South Carolina and received his M.D. degree in December 1958. He was a member of the Alpha Kappa Kappa Medical Fraternity and recently completed his internship at the Columbia Hospital.

Dr. Harrison is a member of the Tri-State Medical Society, The American Academy of General Practice and the Columbia Medical Society.

Seven doctors of Laurens have published the following—

Effective January 1, 1960 Medical Fees will be as follows:

Office Calls \$4 — House Calls \$5 — Night Calls \$7 — Obstetrical Cases \$100.

INTERNAL MEDICINE SOCIETY ELECTS COLUMBIA PHYSICIAN

Dr. A. Izard Josey of Columbia has been elected president of the South Carolina Society of Internal Medicine.

Other officers elected in a recent meeting at the Medical College Hospital are Dr. R. Cathcart Smith of Conway, vice president; Dr. Ralph R. Coleman of Charleston, secretary and treasurer.

The organization, which is a component society of the American Society of Internal Medicine, is composed of internists in the state whose practice is limited to internal medicine.

Several scientific papers were given during the meeting by Doctors H. R. Pratt-Thomas, John Buse, W. M. McCord and James A. Richardson.

DR. JENKINS OPENS OFFICE FOR PRACTICE

Announcement of the opening of offices for the practice of general medicine was made by Dr. Arthur Simons Jenkins, whose residence and offices are located at 2109 Bay Street, Beaufort, S. C.

Dr. Jenkins was born in Kobe, Japan, where his parents were serving as missionaries. Returning from Japan in 1931, he resided in North Carolina until graduating from Davidson College in 1949, at which time he moved to Columbia where he engaged in business prior to entering the Army in 1951. After service in Korea, he was discharged in 1953 at which time he entered the Medical College of South Carolina, graduating in 1957. There followed a year of rotating internship at the Medical College of Virginia, Richmond, and 18 months as a resident physician in internal medicine and pediatrics at Columbia Hospital, Columbia.

He is a member of Shandon Presbyterian Church of Columbia, Alpha Kappa Kappa medical fraternity, and the St. Cecilia Society.

The Man of the Year award at Chester went to the president of the Junior Chamber of Commerce, Dr. H. M. Stone. He is also a member of Purity Presbyterian Church, the Moose, American Legion, Veterans of Foreign Wars and on the board of directors of the Little Boys Baseball League.

He is chief of staff of Chester County Hospital, president of the Chester County Medical Society, interim medical director of the Chester County Hospital; member of the Chester County Cancer Society and a member of the Chester County Board of Commerce and Development.

DR. J. M. BENNETT BEGINS GENERAL PRACTICE HERE

Dr. J. M. Bennett has moved here from Allendale and has begun a general practice of medicine in Belton, replacing Dr. L. W. Douglas, who has entered the service of the U. S. Navy.

Dr. Bennett is occupying the offices of Dr. Douglas and is assuming his practice.

Dr. Bennett is a native of Ruffin, S. C. He is a graduate of the School of Pharmacy of the Medical College of South Carolina and the Medical College of S. C.

He served his internship at St. Louis City Hospital and at Spartanburg General Hospital, Spartanburg, S. C.

Dr. Bennett has been in active practice at Allendale since January 1959.

PHYSICIANS ELECT NEW OFFICERS FOR COUNTY ASSOCIATION

At a meeting of the Marion County Medical Association, held recently at Little Pee Dee Lodge, the following officers were elected:

Dr. Tom Clark, President for 1960.

Dr. Randy Elvington, President-elect.

Dr. M. E. Rice, vice-president.

Dr. D. G. Kitchen, secretary-treasurer.

Dr. Sam Cantey, delegate to the state meeting.

Dr. H. S. Gilmore, alternate delegate.

Dr. Elliott Finger was nominated as president of the Pee Dee Medical Society.

Edward C. Frank, M. D. announces the opening of his office for the practice of General and Chest Surgery, Medical Center Building, Spartanburg, S. C.

NEW OFFICERS NAMED

New officers of the Pickens County Medical Society are: Dr. William Hilton, president; Dr. E. A. Jamison, vice-president; and Dr. George Smith, secretary-treasurer.

Delegates to the State Medical Convention are Dr. J. C. Cutchin, Dr. T. P. Valley and Dr. J. A. White, alternate. Named to the Board of Census were Dr. R. H. Bowick and Dr. John Harden.

HOSPITAL STAFF

New officers of the Pickens County Medical Society and of the Medical Staff of the Easley Baptist Hospital were recently elected by members of the two groups.

New medical staff officers are headed by Dr. E. A. Jamison as chief of staff, Dr. William McCuen as co-chief, and Dr. George Smith as secretary-treasurer. Executive committee members are Dr. William Hilton and Dr. Sydney Garrett.

Retiring officers were Dr. J. H. Jameson, chief of staff; Dr. E. A. Jamison, co-chief; and Dr. Edwin Bradley, secretary-treasurer.

BENNETTSVILLE MEETING

Approximately 100 physicians and surgeons of the two Carolinas, Georgia and Virginia participated in the annual dinner meeting of the Marlboro Medical Society, Thursday night, January 14. The local group met jointly with the Pee Dee Medical Society at the Country Club. Highlight was the address by Dr. George Bennett, director of the Warm Springs, Ga., Foundation, who discussed physical therapy in treating for arthritis and strokes.

DEATHS

DR. R. H. TIMMERMAN

Dr. Ranson Hodges Timmerman, 94, of Trenton, physician of Batesburg for 60 years and brother of Federal Judge George Bell Timmerman, died in Aiken County Hospital on February 9.

Dr. Timmerman was born in Phillippi community of the old Edgefield District and was the son of the late Dr. Washington Hodges Timmerman, who was lieutenant governor and treasurer of South Carolina.

For the past nine years Dr. Timmerman had been retired and made his home near Trenton.

DR. J. C. SEASE

Dr. J. Claude Sease, 67, died suddenly January 31 at his home in Little Mountain.

He was born in Little Mountain, a son of the late Dr. J. Marion Sease and Margaret Monts Sease.

He attended his home town school and was graduated from Newberry College and the Medical College of South Carolina.

After graduation, he served as a lieutenant in the Medical Corps in World War I. Upon his discharge from the service, he became associated with his father in the practice of medicine for 18 years and continued to practice for some time later.

He then entered the public health service and at the time of his death was senior health officer for Newberry, Laurens and Union counties, with headquarters in Newberry.

Dr. Sease was a member of the Newberry Medical Society, of which he had served as president and secretary-treasurer. He served on the procurement and assessment committee in World War II and was councilor for the Third Medical District and was vice president of South Carolina Medical Association in 1954.

He was a Shriner and a member of the Newberry Kiwanis Club. He was also a member of the board of trustees of the Lowman Home at White Rock.

DR. R. L. BURNETT

Funeral services for Dr. R. L. Burnett, 72, of Spartanburg were held January 11. Burial was in Greenlawn Memorial Gardens.

DR. T. B. HARPER

Dr. Thomas Bailey Harper of St. Stephen died January 6 at Charleston after a brief illness. Funeral services were held at St. Stephen.

Dr. Harper was a native of Kingstree. He was born July 10, 1895. Dr. Harper graduated from the Medical College of South Carolina in 1920 and practiced medicine in St. Stephen for the last 30 years.

He was a member of the South Carolina Medical Association, the Berkeley Medical Society and the American Medical Association. He was president of the St. Stephen Lions Club. He was a Mason and a member of St. Stephen Church.

Dr. Harper was vice-chairman of the South Carolina Penitentiary System board. He served under five governors on the board for approximately 15 years.

DR. O. F. HOGAN

Funeral services for Dr. Otto F. Hogan, Sr., 68 were held January 10 in Greeleyville. Burial was in Mt. Hope Cemetery near Greeleyville. He died at Kingstree after a short illness.

He was born at Lynchburg and was graduated from the Medical College of South Carolina in 1916. He had been the practicing physician of Greeleyville for 41 years.

Survivors include Dr. O. F. Hogan, Jr., of Greenville, S. C.

DR. W. C. BOLT

Dr. W. Charles Bolt, 44, died at his home on January 9. Death was believed caused by a heart attack.

A surgeon, Dr. Bolt came to Anderson in 1946. He was a native of Honea Path. He was a veteran of World War II, serving in the Philippines and New Guinea. He was awarded two bronze stars for combat service.

DR. L. KENT BEST

Dr. L. Kent Best of South Windermere died of a heart attack at the age of 55, at a local hospital.

A Charleston eye specialist, Dr. Best maintained offices at 107 Ashley Ave., and lived at 121 Chadwick Drive.

Dr. Best was a graduate of the University of South Carolina and the Medical College of South Carolina. He took up residency after graduation at the Eye and Ear Hospital in Pittsburgh, Pa., and later became clinical assistant in the eye clinic of the University of Pennsylvania graduate hospital.

He entered practice as an eye, ear, nose and throat specialist in 1931 at the Truesdale Clinic in Fall River, Mass. In 1942, he entered the Army Medical Corps as a major and rose to lieutenant colonel upon separation in 1946.

Dr. Best was also a member of the following professional societies: American Academy of Ophthalmology and Otolaryngology, a fellow of the American College of Surgeons, the American Board of Ophthal-

mology, the Massachusetts Medical Society, the International Congress of Ophthalmology, the J. Marion Sims Medical Society of the Medical College of South Carolina, the South Carolina Medical Society, the South Carolina Medical Association, and Phi Chi Medical Fraternity.

In 1958, he was elected to membership in the Oxford (England) Ophthalmological Congress, a society of eye specialists with members mostly of England, Ireland, Scotland and Wales.

ANNOUNCEMENTS

COLUMBIA MEDICAL SOCIETY

Dr. Frederic E. Mohs will be the guest speaker for the Scientific Meeting of the Columbia Medical Society to be held Monday, April 11, 1960. Dr. Mohs is Associate Professor of Chemosurgery at the University of Wisconsin Medical School, and Head of the Chemosurgery Clinic at University Hospitals. He will speak on the subject "Chemosurgery: A New Method for the Microscopically Controlled Excision of External Cancer". His talk will be augmented by a film and lantern slides.

The meeting will be held at the Hotel Columbia, with the social hour beginning at 7:00 P. M., dinner at 7:45, and the scientific session at 8:30 P. M.

All interested physicians are invited to attend.

The regular meeting of the Charleston County Medical Society will be held on April 12, 1960 at 8 p. m. at the Baruch Auditorium. The invited guest will be Dr. Abraham E. Rakoff who is Clinical Professor of Obstetric and Gynecologic Endocrinology at Jefferson Medical College and holds numerous other important positions. He is the co-author of two textbooks and author or co-author of many papers. Dr. Rakoff is not only active in a professional capacity, but carries out a voluminous private practice and directs an active research program. He will speak on the subject "Some Problems of Intersexuality".

A movie on The Forand Bill will be shown.

GILL MEMORIAL EYE, EAR AND THROAT HOSPITAL

and

The Elbyrne G. Gill Eye and Ear Foundation

THIRTY-THIRD ANNUAL

SPRING CONGRESS

in

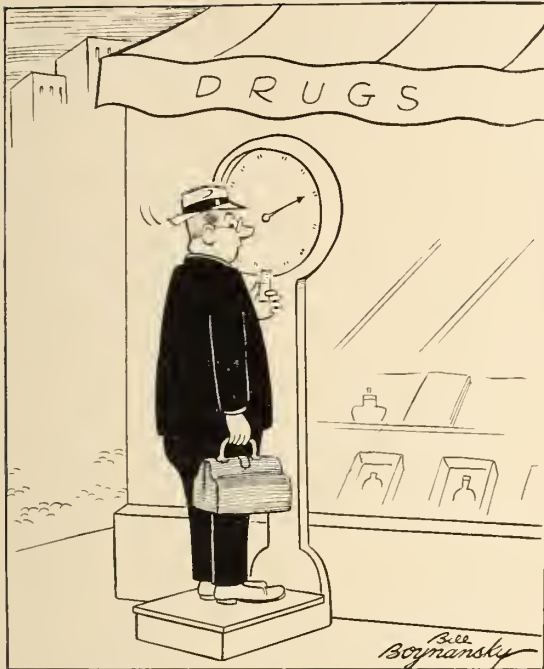
Ophthalmology — Otolaryngology — Rhinology

Laryngoscopy — Maxillofacial Surgery

Bronchoscopy and Esophagoscopy

APRIL 4 through 9, 1960

Roanoke, Virginia



"You are over weight - - - see your doctor!"

RELIGION DABBLES IN MEDICINE

Remedy For Diphtheria

Missions Rooms, 94 Camp Street, New Orleans, February 18, 1861.

TO THE EDITOR OF THE BOSTON JOURNAL:

I see from the papers that diphtheria, or putrid sore throat, is prevailing as a fatal epidemic in some portions of your country. I send you a prescription of one of our eminent physicians, who found it an effectual preventive and remedy during the prevalence of that fatal disease in this city a year ago. I am informed that in the use of it Dr. Benedict did not lose a single patient. I used it myself, as did several clerical friends, and it removed the symptoms by a few applications. I hope you will call the attention of the medical faculty and the public generally to it as a simple and safe remedy.

Yours very truly,
Randolph A. DeLancey

Remedy For Diphtheria Or Sore Throat

Gargle or wash the inside of the throat frequently with a teaspoonful of tincture of black Cohosh, diluted with a little water. Commence using it on the first symptoms of soreness or inflammation. It does not

FOR SALE

By retired physicians, at a sacrifice price, second hand GE Vertical fluoroscope which has had light use and has been pronounced to be in excellent condition by GE technician.

Also one tilt-table fluoroscope in similar condition — Price minimum.

Address inquiries to the Editor, 82 Rutledge Ave., Charleston, S. C.

burn or cauterize, but soothes and relieves the irritation. Do not swallow, as it would nauseate. Continue the use once in two hours until relieved. The tincture can be had at any drugstore.

VETERANS AND PATRIOTISM

Dr. Koontz points with alarm and concern to the errors that have resulted from the passage of a law in 1920 allowing such veterans who were unable to pay the cost of private care to be taken care of in VA hospitals if there was space available. The first result was that the privilege has been abused in the most flagrant fashion. Second, it has caused the empire builders in the VA to clamor for more and more hospitals. Next, after VA hospitals were affiliated with medical schools, the residency system was expanded tremendously. Finally, the VA officials openly say that they must have non-service connected disability cases in order to maintain their residency training program and, according to most reliable information, upwards of 85% of their cases are non-service connected disabilities. It is obvious that the present trend toward free medical care of veterans (and there are 22 million of them including dependents) is a long step toward socialized medicine. Amos R. Koontz, M. D. in *Current Medical Digest*

WANTED: Male psychiatrist; Diplomate or with three years approved training; to join group practice 145-bed approved psychiatric hospital. Salary: \$15,000-\$18,000 first year; \$20,000-\$25,000 second with incentive factor. Write Box A care this Journal.

SCIENTIFIC PROGRAM
SOUTH CAROLINA MEDICAL ASSOCIATION
MYRTLE BEACH, SOUTH CAROLINA

MAY 18-19, 1960

Wednesday, May 18th, 1960:

- 2:00 P. M.—Dr. Kathleen Riley, "Griseofulvin".
—Dr. J. H. Stokes, Symposium on "Glaucoma".
 Dr. J. H. Stokes, Chairman
 Dr. Roderick Maedonald
 Dr. Thomas Gaines
 Dr. Joseph Workman
 Dr. Pierre Jenkins
—Dr. William H. Muller, Jr., "Aortic Valvular Disease".
—Intermission to view Scientific and Commercial Exhibits.

3:30 P. M.—Presidential Address.

- 3:45 P. M.—*Panel Discussion on Cardiovascular Disease:*
(Sponsored by the American Heart Association)
 Dr. Edward F. Parker, Moderator
 Dr. William H. Muller, Jr.
 Dr. Bruce Logue
 Dr. Rhett Talbert

5:15 P. M.—Intermission to view Scientific and Commercial Exhibits.

Thursday, May 19th, 1960:

- 9:00 A. M.—Dr. Robert Cosgrove, "Pregnancy Following Operative Delivery".
 Dr. George W. Anderson, "Obstetrician's Responsibility in the Prevention of
 Neurologic Disease in Children".
—*Panel Discussion on Perinatal Problems:*
(Sponsored by the Division of Maternal and Child Health.)
 Dr. Herbert Black, Moderator
 Dr. George W. Anderson
 Dr. Robert Cosgrove
 Dr. Walter Hart
—Intermission to view Scientific and Commercial Exhibits.
—Dr. Edward Kremenz, "Acute Management of the Severely Burned Patient".

- 11:30 A. M.—*Panel Discussion on Hormone and Chemotherapy of Cancer:*
(Sponsored by the American Cancer Society, South Carolina Division, Inc.)
 Dr. Forde Melver, Moderator
 Dr. A. C. Curreri
 Dr. Edward Kremenz
 Dr. Charleston deSaussure

- 2:00 P. M.—Dr. Arthur C. McCarty, "Leap Year Gerontology and Geriatrics".
—Dr. E. V. Allen, "The Natural History of Arteriosclerosis Obliterans".
—Dr. Kenneth Appel, "Basic Psycho-Therapy".
—Intermission to view Scientific and Commercial Exhibits.
—Dr. Randolph Bradham, "Portal Hypertension and Bleeding Esophageal
Varices".

- 4:00 P. M.—*Panel Discussion on Geriatrics:*
 Dr. Arthur C. McCarty, Moderator
 Dr. E. V. Allen
 Dr. Kenneth Appel
 Dr. Bruce Logue

Detailed Program will be published next month.

SCIENTIFIC PROGRAM COMMITTEE

Dr. Dale Groom, Vice-Chairman
Dr. George Durst
Dr. George Buneh
Dr. Robert Wilson, Ex-Officio

Dr. William Weston, Ex-Officio
Dr. William H. Prioleau, Chairman
158 Rutledge Avenue
Charleston, South Carolina

GREENVILLE POST GRADUATE SEMINAR

APRIL 12, 13, 14, 1960

GREENVILLE GENERAL HOSPITAL

PROGRAM

Tuesday, April 12, 1960

- 8:00 A. M.—Registration
8:30 A. M.—Welcome
9:00 A. M.—Dr. John Evans ----- Pulmonary Embolism
 —Dr. Walton Aikenhead ----- Management of Congestive Heart Failure
 —Dr. Monroe Romansky ---- Factors Influencing the Trend of Antibiotic Therapy
 —Dr. Richard Bloomberg ----- Iatrogenic Illness
 —Question and Answer period for morning lectures.
 Drs. Evans, Aikenhead, Romansky, Bloomberg.
1:10 P. M.—Luncheon
 —Dr. Wendell Thrower ----- Heart Surgery 1960
 —Dr. Arthur M. Pruce ----- Management of Symptom Exaggeration
 —Dr. James P. Mann ----- Bronchitis & Emphysema, The Evolution of.
4:10 P. M.—Question and Answer period for afternoon lectures.
 to Drs. Thrower, Pruce, Mann.
4:30 P. M.

Wednesday, April 13, 1960

- 9:00 A. M.—Dr. Monroe Romansky ----- Steroids and Infectious Diseases
 —Dr. Walton Aikenhead ----- Gastro-Intestinal Hemorrhage
 —Dr. John Evans ----- Management of Coronary Heart Disease
 —Dr. James P. Mann ----- Bronchitis & Emphysema, The Therapy of
12:40 P. M.—Question and Answer period for morning lectures.
 Drs. Romansky, Aikenhead, Evans, Mann.
1:10 P. M.—Luncheon
 —Dr. John Cuttino ----- The Diagnoses Most Often made Post-mortem
 —Dr. Vince Moselev ----- Tips on How to Make more of these Diagnoses Ante-mortem
 —Dr. Richard Bloomberg ----- The Management of "Staph" Pneumonia
4:10 P. M.—Question and Answer period for afternoon lectures.
 to Drs. Cuttino, Moseley, Bloomberg.
4:30 P. M.

Thursday, April 14, 1960

- 9:00 A. M.—Dr. Walton Aikenhead ----- Management of Acute Renal Failure
 —Dr. Richard Bloomberg ----- Primary Tuberculosis in Children
 —Dr. James P. Mann ----- Pulmonary Suppurative Disease
 —Dr. Charles W. Hock ---- Medical Management of the Normal "unwell" patient
12:40 P. M.—Question and Answer period for morning lectures.
 Drs. Aikenhead, Bloomberg, Mann, Hock.
1:10 P. M.—Luncheon
 —Dr. Wendell Thrower ----- What Future Progress in Heart Surgery Offers
 —Dr. John Evans ----- Diuretic Therapy
 —Dr. Monroe Romansky ----- The Staphylococcal Problem and its Therapy
4:10 P. M.—Question and Answer period for afternoon lectures.
 to Drs. Thrower, Evans, Romansky.
4:30 P. M.

PROGRAM

TRI-STATE MEDICAL ASSOCIATION ANNUAL MEETING

March 21 and 22, 1960

Columbia Hotel, Columbia, S. C.

Monday, March 21

- 9:30 A. M.—Paper—"Current Medical Treatment of Hyper-Cholesterolemia and Hyperlipemia and Atherosclerosis"—Dr. Edwin Boyle, Jr., Charleston, S. C.
10:00 A. M.—Paper—"Recent Surgical Developments in Hypertension and Peptic Ulcer,"—Dr. Keith S. Grimson, Durham, N. C.
11:00 A. M.—Paper—"What Do Simple Kidney Function Tests Mean?"—Dr. Cheves McC. Smythe, Charleston, S. C.
11:30 A. M.—Paper—"Neurological Complications of Disease of the Cervical Spine,"—Dr. Rhett Talbert, Charleston, S. C.
12:00 Noon—Paper—"Diagnosis and Medical Management of Bleeding Esophageal Varices,"—Dr. Malcolm P. Tyor, Durham, N. C.

12:30 to 2:00 P. M.—Luncheon Panel

Dr. Keith Grimson, Moderator, Dr. Edwin Bovle, Jr., Dr. Cheves McC. Smythe, Dr. Rhett Talbert, and Dr. Malcolm P. Tyor

2:00 P. M.—Paper—"Pulmonary Alveolar Proteinosis"—Dr. William Schulze, Greenville, S. C.

2:30 P. M.—Paper—"The Role of Ascorbic Acid in Human Pathology"—Dr. Fred R. Klenner, Reidsville, N. C.

3:30 P. M.—Panel on Psychosomatic Medicine

(a) Dr. Charles Fulghum, Department of Psychiatry and Neurology, Emory University Medical College, Atlanta, Ga.

(b) "How the Treatment of Some of the Aged Psychotics Can be Effective"—Dr. James Asa Shield, Chief of Department of Psychiatry and Neurology, Medical College of Virginia, Richmond, Va.

(c) "Somatophytic Manifestations of Disease"—Dr. Vince Moseley, Chief of Department of Medicine, Medical College of South Carolina, Charleston, S. C.

(d) "Psychosomatic Problems in General Practice"—Dr. William Hendrix, President of S. C. Chapter of the American Academy of General Practice, Spartanburg, S. C.

(e) General discussion by Drs. Fulghum, Shield, Moseley and Hendrix with questions from the floor.

Tuesday, March 22

8:30 A. M.—Paper—"Blood Sugar and Urine Sugar Determinations in the Diagnosis and Management of Diabetes"—Dr. William R. Jordan, Richmond, Va.

9:00 A. M.—Paper—"Office Urology"—Dr. Kenneth M. Lynch, Jr., Charleston, S. C.

9:30 A. M.—Paper—"Surgical Treatment of Facial Injuries"—Dr. C. C. Coleman, Jr., Charlottesville, Va.

10:00 A. M.—Paper—"Endocrine Therapy In General Practice"—Dr. J. Richard Sosnowski, Charleston, S. C.

11:00 A. M.—Paper—"The Treatment of Congestive Heart Failure"—Dr. Paul D. Camp, Richmond, Va.

11:30 A. M.—Paper—"The Treatment of Electrolyte Emergencies"—Dr. Dana C. Mitchell, Jr., Columbia, S. C.

12:00 Noon—Paper—"Diagnosis and Treatment of Respiratory Infections in Children"—Dr. George Dean Johnson Spartanburg, S. C.

12:30 to 2:00 P. M.—Luncheon—Panel

Dr. C. C. Coleman, Jr., Moderator, Dr. Paul D. Camp, Dr. Kenneth M. Lynch, Jr., Dr. Dana C. Mitchell, Jr., Dr. George D. Johnson, Dr. J. Richard Sosnowski and Dr. William R. Jordan.

2:00 P. M.—Paper—"Problems in Immunization Against Infectious Diseases"—Dr. Samuel F. Ravenel, Greensboro, N. C.

3:00 to 4:30 P. M.—Panel on Thyroid Disease

(a) "Problems in Diagnosis and Treatment of Thyroid Disease"—Dr. William H. Prioleau, Moderator, Clinical Professor of Surgery, Medical College of S. C., Charleston, S. C.

(b) "Medical Evaluation in Thyroid Disease"—Dr. Ben N. Miller, Senior Visiting Staff, Internal Medicine, Columbia Hospital, Columbia, S. C.

(c) "Pathological Pitfalls in the Diagnosis of Thyroid Lesions"—Dr. Rawling Pratt-Thomas, Professor of Pathology, Medical College of South Carolina, Charleston, S. C.

(d) "Behavior of the Thyroid During Pregnancy"—Dr. Luther Talbert, Department of Obstetrics and Gynecology, University of North Carolina, Chapel Hill, N. C.

(e) General Discussion by Drs. Prioleau, Miller, Pratt-Thomas and Talbert with questions from the floor.

BOOK REVIEWS

LABORATORY MEDICINE — HEMATOLOGY.

1st Ed. By John B. Miale, M. D. 735 pages. C. V. Mosby Company. 1958. \$13.75.

With the increasing number of manuals and texts on hematological techniques and methods being published yearly, it is difficult to have any one stand out. However, Dr. Miale has done this admirably in the

present work, and he has produced an excellent review of this important subject.

The illustrations, in color and black and white, are well chosen, and the discussion of the morphology of blood and bone marrow cells is clear and concise. The metabolism of the red cell is briefly covered and newer techniques to study these processes are clearly outlined. A discussion of the hemorrhagic diseases is done in a lucid manner and the terminology is made relatively easy to understand. The various examinations of the blood are clearly described with a good

explanation of the basis for them and pitfalls associated, which is indispensable for the student.

This is the first of three volumes on *Laboratory Medicine*, the next two being on Chemical Pathology and Microbiology. It can be highly recommended to medical students and practitioners as a text and a reference work.

Charlton deSaussure, M. D.

THAT THE PATIENT MAY KNOW. Henry F. Dowling, M. D. and Tom Jones. W. B. Saunders Co., Philadelphia. 1959. \$7.50.

This 139 page atlas of graphic pictures and diagrams illustrating every organ system of the body fills a real need. The sketches are well done, free of extraneous detail, and would offer much aid to the physician as he explains a process, a disease, or a surgical procedure to his patient.

The section on diabetes is particularly valuable, embodying the exchange diet plan, sketches on administration of insulin, care of the feet, etc.

The limited specialist would perhaps wish for more illustrations in his field. For example the section on the gastrointestinal system fails to show the complications of peptic ulcer, omits hiatus hernia in adults, and does not sketch the surgical attack on ulcer. Perhaps more importantly, functional processes, such as pylorospasm and the spastic colon, are not shown and these are perhaps more needed in explaining gastrointestinal symptoms than some organic process such as gallstones. However the generalist will find much use for this atlas as it lends the authority of the printed page to his explanation, shortens time needed for explanations, and helps to make them accurate.

C. L. Legerton, M. D.

MANUAL OF SKIN DISEASES. By Gordon C. Sauer, M. D. First Edition, J. B. Lippincott Company, Philadelphia. 1959. Pp 269, Price \$9.75.

The author's stated purpose of this manual is to present "a book with only the material that medical students and general practitioners must know for the diagnosis and the treatment of patients with common skin diseases". His adequate and simplified outline fulfills this purpose.

This book is essentially an emergency textbook of dermatology which the general practitioner could use in a large majority of his cases. For the busy practitioner the simple outline of treatment, especially the follow-up treatment is valuable.

The color pictures strike one as being unusually good, as good as those found in medical advertisements. They are good, if not better, than any other color pictures seen in dermatology textbooks. These pictures were contributed by different drug companies who have underwritten the cost in printing so that the book price can be kept in range.

Kathleen Riley, M. D.

THE MEGALOBlastic ANEMIAS. 1st Ed. Victor Herbert, M. D. 160 pages. Grune and Stratton, New York. 1959. Price: \$6.00.

Knowledge regarding the pathogenesis and treatment of the megaloblastic anemias has increased greatly in the past decade following the isolation of folic acid and vitamin B₁₂. Dr. Herbert's monograph is based on this extensive literature and his own experimental studies in the field, and he very ably summarizes the present state of knowledge.

Abnormalities of nucleic acid metabolism are discussed as well as the morphological changes associated with B₁₂ or folic acid deficiency, and the aid in diagnosis this gives. The etiological classification of B₁₂ and folic acid deficiencies is next covered, showing how inadequate intake, defective absorption, or defective utilization of each of these substances can give a megaloblastic anemia. The therapy is well reviewed, although little new can be added here.

This is a very complete survey of the field and would be well worth while for anyone interested in the subject.

Charlton deSaussure, M. D.

PROGRESS IN HEMATOLOGY. Volume II. By Leandro M. Tocantins, M. D. 290 pages. Grune and Stratton, New York. 1959. Price: \$9.75.

This is the second symposium on recent advances in the field of hematology, and once again is ably edited by Dr. Tocantins. It includes thirteen papers on topics of current interest to the hematologist, but not necessarily to the general clinician. Review articles on the use of myleran in chronic myeloid leukemia, platelet transfusions, and bone marrow transplantation are well done and should be perused by the well-rounded practitioner.

Approximately one-half of the articles are on methodology or biochemical studies of the red cell, which is now proving extremely fruitful in the understanding of many hematological disorders. However, even for a hematologist not actively engaged in the particular field, it would seem to be much too detailed for an over-all progress report.

This volume does not measure up to the first, which was of more general information and is not recommended except as a reference source for further material on some detailed point.

Charlton deSaussure, M. D.

THE PREPARATION OF MEDICAL LITERATURE, by Louise Montgomery Cross. J. B. Lippincott Co.: Philadelphia, 1959. Price \$10.00.

Given the spark of inspiration for the preparation of the medical paper, or the urge to plodding presentation of medical data, one need lack no guide to getting through the field of common errors of composition and arrangement.

There are a number of very good books which have to do with the preparation of scientific papers and

most of them cover a somewhat wider field than does this particular book. This is intended to be used as a desk reference, one which can be picked up and consulted for detail of the technique of preparation of the paper. It goes rather far into detail in the matters which it covers, and assumes a rather serious attitude without much lightness of touch, following a middle course in most situations. The usual horrible examples of transgressions by medical writers are to be found in its pages. More than the usual space is devoted to matters of selection and preparation of illustrations, perhaps even to the point of a little more detail than seems necessary for the average writer. A useful list of abbreviations of titles of medical journals completes the volume.

Consultation with this book should certainly make better writers of poor writers, and the results of its advice well taken should be most pleasant to editors to whom the papers come. All the necessary information is there, simply put, and pleasingly presented. This should be a useful book.

JIW

PROBLEMS OF ADDICTION AND HABITUATION: Edited by Paul H. Hoch. New York: Grune and Stratton. 1958. Pp. 250. Price \$6.50.

This volume is a discussion of addictions and habituations to alcohol and various drugs by fifteen leading authorities in this field. These papers were presented at a symposium during the 47th annual meeting of the American Psychopathological Association, held in New York City, February 1957.

While this book is intended primarily for psychiatrists, it will also prove of interest to those in general practice, surgery and all others interested in the problems of addiction. The mechanisms of addiction are thoroughly explored and follow the generally accepted concept that both narcotic addiction as well as chronic alcoholism and addiction to other drugs represent an illness of the total personality of the addicted individual. In the case of narcotic addicts it is clearly pointed out that in some of these individuals the physician plays a vital role in the onset of addiction. Case studies on these individuals, who stated that their addiction was initiated by a physician during a course of illness or following surgery, indicate that such individuals have little tolerance for pain or discomfort of any type and consequently are predisposed to addiction because of their personality structure. Much helpful information regarding the recognition of this type of patient and the avoidance of these pitfalls in the use of narcotics and other addicting drugs is included and makes this book all the more valuable to the practicing physician and surgeon.

The magnitude of the problem of narcotic addiction in the U. S. A. is presented in a most informative and readable manner by W. Lee Speer, Field Supervisor of Enforcement Activities, Federal Bureau of Narcotics. This thoroughly documented re-

port includes recent studies of the various aspects of the problem in the large cities of this country as well as some special aspects peculiar to certain states. The recommendations of the medical experts of the U. S. Public Health Service, who are assigned to this special area of service, are included and appear well worth the careful consideration of all physicians concerned with the increasing problem of addiction. A somewhat different viewpoint and approach is given in considerable detail by Dr. Karl Bowman, a psychiatrist of considerable authority and eminence.

The material relative to the alcoholic problem, while considerably less in volume than that devoted to drugs, is of the same high quality and well worth the readers effort and time.

Edward M. Burn, M. D.

A HISTORY OF THE AMERICAN DENTAL ASSOCIATION 1859-1959: A CENTURY OF HEALTH SERVICE by Robert W. McCluggage, Ph. D., of the Department of History, Loyola University, Chicago, was published by the Association on September 14.

Copies of the book may be obtained through the American Dental Association, 222 East Superior Street, Chicago 11, Illinois at \$8.00 (\$12.50 in a special red-leather binding).

Publications of the National Medical Foundation for Eye Care, 257 W. 57th Street, New York 19, N. Y. "What is an Ophthalmologist" defines the optometrist and optician.

"Medicine, Optometry, and The Public Welfare", is primarily a report to the Medical profession.

A booklet titled "An Analysis of Certain Legislative Proposals Affecting Eye Care", describes some of the legislative devices which organized optometry has used or attempted to use in various states to gain recognition or prerogatives beyond their training and technical functions.

"OPHTHALMOLOGY AS A VOCATION", by Harold F. Falls, M. D.

"WHY DROPS?" (Popular leaflet on uses of mydriatics)

"EYE CARE AND PREPAYMENT PLANS" (Foundation Report #5 describing existing programs and outlining principles for ophthalmological service plans — 38 pages)

"THE ANCILLARY WORKER IN OPHTHALMOLOGICAL MEDICAL PRACTICE". PART I—"THE OPTICIAN" (Foundation Report #6 stating principles governing ancillary workers and the role of the optician—14 pages)

"IDENTIFICATION OF SCHOOL CHILDREN REQUIRING EYE CARE" (Foundation Report #7 to Educators and Physicians on school screening problems and procedures—36 pages)

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the Foundation also makes available a Glaucoma Identification Card for the convenience and protection of glaucoma patients.

PREVENTIVE MEDICINE IN WORLD WAR II: Volume IV. COMMUNICABLE DISEASES TRANSMITTED CHIEFLY THROUGH RESPIRATORY AND ALIMENTARY TRACTS, E. C. Hoff, Editor. Superintendent of Documents, Washington. 1958. Pp. 544. Price \$5.50. Part of the official history of the Army Medical Department. Each chapter contributed by a recognized medical authority. An authoritative distillation of experiences of a controlled mass of healthy young men as they encountered incidentally the major communicable diseases in a global variety of environmental situations. Absorbing for participants in World War II, and for students of communicable disease, preventive medicine, and military medicine. Analyzes preventive measures applicable to 1945 and describes war-time research in new diseases and new preventives. Interesting in detail, sound in summary and conclusions. This volume reads well solo yet is well complemented by prior volumes on *ENVIRONMENTAL HYGIENE* and *PERSONAL HEALTH MEASURES AND IMMUNIZATION*. Two other communicable disease volumes will follow. The series is ably reviewed in the February, 1959, *Public Health Reports*.

Malcolm U. Dantzler, M. D.

A TEXTBOOK OF MEDICINE, Edited by Russell L. Cecil, M.D., Sc.D., and Robert F. Loeb, M.D., Sc.D., LL.D., and Associates. Written by 164 authors. Tenth Edition. W. B. Saunders Co., Philadelphia, Penn., pp1665. Price \$16.50 single volume; double \$20.50.

This well-known text was first issued in 1927, and with the years has been often refreshed, and maintains its usefulness and popularity. The single volume, which is at hand, seems well bound in gray buckram. The double volumes must be designed for ease in hand-

ling, since the single is of necessity quite heavy, although pleasantly flexible.

As usual, the list of authors is quite impressive, well known in their various fields. New articles have been added, in virology, as might be expected, and other fields.

One inescapable defect in a compilation of this sort is the uneven quality of the writing, but there is the fact that the whole volume then escapes having been written by those with the least happy styles.

This is an admirable work, and for quick reference on a surprisingly broad scale, it would be difficult to surpass.

J. O'Hear

SYNOPSIS OF EAR, NOSE, AND THROAT DISEASES. R. E. Ryan, W. C. Thornell, and Hans Von Leden. The C. V. Mosby Co., St. Louis 1959. Price, \$6.75.

This volume contains a great deal of valuable information, in a condensed as well as in an outlined form.

The chapters on diseases of the larynx are clear and concise. The anatomy and physiology of the laryngeal muscles are presented in a way as to be easily remembered.

A discussion on tracheotomy and its indications is noteworthy.

The diseases of the ear are amply discussed; very little mention is made of the more recent surgical treatment such as tympanoplastic work. However, one would not expect this in a book dealing with disease descriptions rather than surgical technique.

The tonsil and adenoid question is very well presented; the indications for surgery are very clearly presented. Several good diagrammatic illustrations show the methods employed.

This book can be recommended for use by medical students and physicians who wish to have a handy condensed reference on diseases of the ear, nose, and throat.

A. L. Feuer

The South Carolina Medical Association urges you to

FIGHT FOR AND

Send a handwritten letter to your congressmen and any others who may have a voice or a vote.

The Journal

of the

South Carolina Medical Association

VOLUME LVI

April, 1960

NUMBER 4

MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

Intermittent bundle branch block in coronary disease

DALE GROOM, M. D.
Dept. of Medicine

Case Record—A 68 year old accountant complained of pain in the mid-chest coming on with exertion and promptly relieved by nitroglycerin. Recently the pain had awakened him occasionally at night, lasting 15 to 20 minutes and accompanied by anxiety and sweating. The clinical picture was complicated by the presence of daily epigastric pain which the patient attributed to a peptic ulcer of many years standing. At one time he had been given digitalis for dyspnea and he continued to take this though it had no appreciable effect on his symptoms.

The significant findings on examination were the blood pressure of 162/86, moderate narrowing and sclerosis of the retinal arterioles indicative of pre-existing hypertension, and diminished pulsation of the femoral arteries, especially on the left side where all pulses below were absent. A chest roentgenogram showed calcium in the wall of the aortic arch and rounding of the cardiac apex suggestive of minimal left ventricular enlargement.

The electrocardiogram on the right was made immediately after mild physical exertion (walking slowly up and down two steps twelve times) which was insufficient to reproduce his symptoms. Within a few minutes thereafter his electrocardiogram reverted to the essentially normal pattern of the resting tracing on the left.

Six months later the patient died in pulmonary edema within an hour after being seized with severe substernal pain.

Electrocardiograms—While perhaps not entirely normal, the resting tracing has no changes which could be considered diagnostic of coronary disease. The T

waves are unusually peaked in some precordial leads, as is often seen with involvement of the posterior wall, but there are no significant QRS abnormalities. Minimal T wave changes attributable to digitalis effect are seen in leads II, III and aVF.

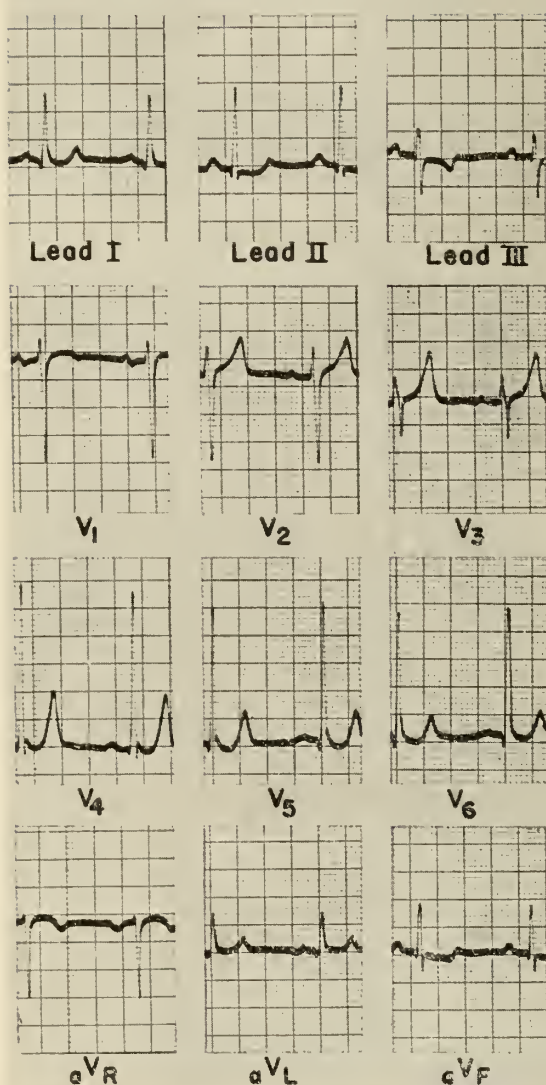
Following exercise there are gross changes in all the ventricular complexes. Width of the QRS is doubled to 0.12, the configuration becoming variously slurred or notched, and there are both S-T and T wave abnormalities typical of bundle branch block. The tiny Q waves of septal activation, previously present in V₅ and V₆, have disappeared. A delay in depolarization of the left ventricle is indicated in aVL where the intrinsicoid deflection occurs 0.08 sec. after onset of the QRS. The R waves have disappeared from the right precordial leads and the T waves are generally in a direction opposite to the main deflection of their QRS complexes.

Note that while the heart rate has increased from 75 to 92 the P-R interval has become slightly longer, measuring 0.20 after exercise, 0.18 before.

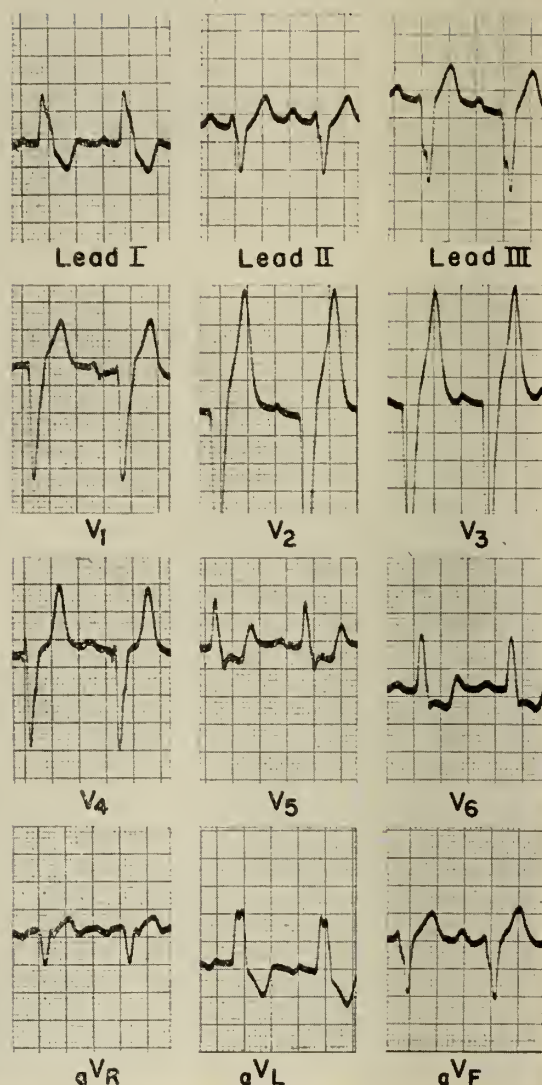
Discussion—Electrocardiograms of course show what has happened, not what will happen to the heart in respect to coronary disease. Attempts to look beyond the status quo and to some extent predict coronary insufficiency—or, more properly perhaps, to establish that diagnosis in the presence of a normal resting electrocardiogram—are the several types of stress tests including the exercise routine utilizing two steps of standard height devised by Master several years ago. Such tests are based on the logical premise that the way to evaluate the reserve of an organ is to put it under stress. Although false negative results are common and false positives do occur, these tests have their greatest usefulness in providing objective evidence of coronary insufficiency and are commonly employed in the differential diagnosis of chest pain. They contribute no additional information and are actually contraindicated when the resting electrocardiogram is already diagnostic or significantly abnormal.

To the usual criteria of a positive exercise test

Before Exercise



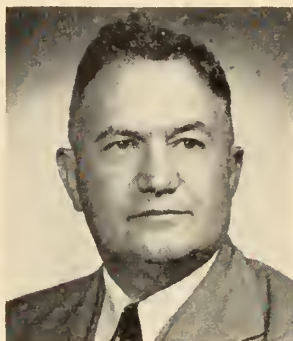
After Exercise



(S-T segment displacements, exercise-induced arrhythmias, and perhaps gross T wave changes) should be added the induction of major conduction defects such as bundle branch block. Almost always, left bundle branch block is indicative of organic heart disease—commonly, coronary sclerosis and conditions which place mechanical stress on the left ventricle, as hypertension or an aortic valve lesion. It is reasonable to assume that the transient appearance of this conduction defect with exercise is a manifestation of insufficient coronary blood flow to the region of the bundle, although one might postulate a stretching of the septum by the concurrent rise in intra-ventricular

pressure. Transient bundle branch block is occasionally observed in acute myocardial infarction, in myocarditis, in pulmonary embolism (*right bundle branch block*) and in various toxic states. Ordinarily it is a permanent electrocardiographic abnormality.

Other ECG manifestations of the induced ischemia in this patient are of course obscured by the presence of the conduction defect which itself causes S-T displacements and T wave abnormalities, as well as the loss of R waves and other QRS alterations. Transient left bundle branch block is a rare but highly significant finding in "stress" electrocardiograms.



PRESIDENT'S PAGE

"Have physicians' fees increased more than fees for other services since the principal inflationary push began in 1938? The answer is no.

In fact the percentage of increase in MDs' fees during the past 20 years has been less than the increase for most other services.

From 1938 to 1958 physicians' fees increased 83.9%. But look what happened to fees for some of the other services during that period: Domestic service up 278.9%; men's haircuts up 207%; shoe repairs up 152.4%; laundry service up 115.2%; transportation up 95.4%; automobile repairs up 93.9%.

Some services such as television repairs were not included in the consumer price index prior to 1953. But from 1953 to 1958, TV repairs increased 28.9%; house painting (interior) 25.4%; home maintenance and repairs 14.8%. During that same six-year period physicians' fees increased 18.3%.

No one will deny that fees for all services have increased substantially during the two-decade inflationary period, but physicians' fees have been a follower in this trend—not a leader."

Everything has increased in price above medical care. There was no quotation from several businesses which are frequently needed in the home such as plumbing, electricity, and television which have increased far and beyond all reasonable expectation. As a matter of fact, in some places this increase has been classified as a monetary racket.

My figures quoted above are correct, and this means that by far the majority of us do not and will never fleece the public. There are a few in our profession who need to read and re-read the Hippocratic oath too that they may practice like our forebears. This minute group gorges the citizens thus bringing disrepute to the entire profession. If our house of doctors (M.D.'s) is not in order let's put it in order by placing these money mad M.D.'s on probation and let our own societies and the people know that we can do and will do better medicine and surgery than our predecessors.

Thank goodness there are very few in South Carolina who need correcting, but it is easy for the disease to spread so we must stop it in its infancy in order that the citizenry should have the faith and respect in all our physicians and surgeons. Let's clasp hands with each other and go forward in a maneuver with our heads held high and allow all to be proud of our profession.

William Weston, Jr.

Editorials

THE PROGRAM

Elsewhere in this Journal there appears the forthcoming program of the South Carolina Medical Association. A great deal of thought and effort have gone into the formulating of this program which was designed to be of maximum interest and value to the greatest number of members and carries what is undoubtedly one of the most formidable rosters of medical speakers to appear on a Scientific Program in our State. We are indebted to the several agencies of our State Board of Health and to the South Carolina Heart Association for their support in sharing the expenses of guest speakers, and particularly to the speakers themselves who are taking time out from busy schedules to make their personal contributions to our Annual Convention.

For us, the members, this program affords a major savings in time and expense in that we can enjoy here what ordinarily we would have to journey far to attend. Among the highlights will be four panel discussions featuring outstanding authorities in the fields of cardiovascular disease, psychiatry, rheumatology, surgery, obstetrics, etc., as well as a symposium on glaucoma in general practice put on by our own ophthalmologists under the leadership of Dr. Howard Stokes. And for the finale, the Senior Statesman of South Carolina, The Honorable James F. Byrnes will share honors with the President-elect of the American Medical Association, Dr. Vincent Askey, as speakers at the annual banquet and ball for the Alumni Association and guests, which of course includes the ladies. The program has been approved for credit in category I by the Academy of General Practice.

So before that appointment book gets too filled up, cross off now *May 18 and 19* and join us at Myrtle Beach!

ACRONYMS

These columns have groaned more than once on the subject of the unwarranted use of

obscure and unintelligible abbreviations. Hospital charts are crowded with them, manuscripts contain not a few, and the meaning of many an article is rendered obscure by the appearance of some quite meaningless set of capital letters.

Even so it was hard to realize that there is now available a book which lists more than 12,000 acronyms, ranging from such things as CARE (Cooperative for American Remittances to Everywhere), DEW (Distant Early Warning), MUTT (Military Utility Tactical Truck), WAC, RAMAC, UNIVAC, IOOF, and so on and on and on.

These things may serve a useful purpose in conserving type and space, but unless one has this 12,000 word book handy, he is very apt to get entirely confused as to what the author of a paper is trying to say. Certainly in medicine there is little excuse for the innumerable abbreviations, of which a few are generally recognized and intelligible, but of which the vast majority are pure inventions of the individual recorder's lazy brain.

JIW

RETICENT REPORTERS

In the several reliable reports available, there is to be noted a remarkable decline in the number of communicable diseases in South Carolina. It would be nice to think that this is a true picture, but the suspicion cannot be dispelled that a great number of our doctors are failing to carry out their legally prescribed duty of reporting all cases of certain diseases in the state.

"HOUSE CALL"

"House Call", a 30-minute television panel initiated by the South Carolina Medical Association in November is continuing to receive enthusiastic acceptance by viewers throughout the state.

Much of the success of this program is traceable to the excellent performances given by local doctors.

In the Charleston area Dr. George Durst, Dr. Robert Wilson and Dr. Charlton deSausure presented the first panel discussion, "The Hospitalization and Care of the Aged" on W U S N, Channel 2 in December.

A second program on "Food Faddism" was presented by Dr. John Buse, Dr. Edwin Boyle and Dr. Clarence W. Legerton on February 14. Future programs are now scheduled on W U S N on a month-to-month basis.

Monthly scheduling is also arranged on Columbia station, W I S. The first program was given on February 27 with participating doctors, Harvey Atwill, Jr., James T. Green, W. C. Cantey, C. Warren Irvin, Jr. and Richard J. Kahaly. Dr. William M. Bryan moderated the panel. A second program will appear on March 26.

Greenville station W F B C carried "House Call" in November with panelists Dr. John Fewell, Dr. George Wilkinson, Jr., Dr. Leon Marder and Dr. William R. Craig. A second program is tentatively scheduled for March 20th.

At this time plans for "House Call" programs in Spartanburg and Florence are also nearing completion. The first Spartanburg panel will include Dr. A. S. Pearson, Dr. William Blanton, Dr. W. A. Wallace and Dr. W. N. Cochran. The Florence panel will be reported later.

A STATEMENT ON ARTERIOSCLEROSIS:

Main Cause of "Heart Attacks" and "Strokes"

By Paul Dudley White, M. D.; Howard B. Sprague, M. D.; Jeremiah Stamler, M. D.; Frederick J. Stare, M. D.; Irving S. Wright, M. D.; Lonis N. Katz, M. D.; Samuel L. Levine, M. D.; Irvine H. Page, M. D. Supported by 106 Members of the American Society for the Study of Arteriosclerosis. National Health Education Committee, Inc. New York, N. Y.

Eight leading U. S. physicians and 106 members of the American Society for the Study of Arteriosclerosis concurred on a statement designed to help people avoid heart attacks and strokes due to arteriosclerosis—by far the leading causes of death in the Western World. *Fifty per cent of all deaths in the United States today are caused by arterio-*

sclerosis and hypertension. Recent and current researches provide hope for improved treatment of arteriosclerosis and possibly for preventive measures.

This statement of guidance summarizes useful information on these points. While it is realized that a definitive statement may be modified, at least in part, by future research, nevertheless, it is believed that on the basis of current evidence and experience this statement provides information that will prolong the life of many citizens at this time.

The statement says, in part: "Factors which predispose YOU to arteriosclerosis, heart attack, and stroke are: Overweight, elevated blood cholesterol level, elevated blood pressure, excessive cigarette smoking, and heredity.

"You can't change your heredity but you can influence the other factors and hence lessen your chances of being a victim of cardiovascular disease. If there is a history of cardiovascular trouble in your family, it just means you should be especially careful about factors you can control. On the key factors of overweight, cholesterol count, blood pressure and cigarette smoking, *you should without fail consult your physician.*

"Any definitive statement about arteriosclerosis and its principal manifestations—coronary thrombosis (heart attack) and cerebral thrombosis (stroke)—will be modified as future research indicates. Based on present knowledge, your careful attention to the points mentioned above is a sensible way to try to lessen your chances of becoming a victim of these killers."

The doctors' comment contained this statement: "Hard work itself is often wrongly blamed for this disease. In fact, regular, moderate, physical activity appears to lessen the hazards of arteriosclerosis."

PAN AMERICAN MEDICAL ASSOCIATION CONGRESS

Mexico City, May 2 to 11, 1960.

For information write Dr. Joseph J. Eller.

Director General, 745 Fifth Avenue, New York, N. Y.

MEETING OF COUNTY SOCIETY OFFICIALS

South Carolina's physicians have been urged to renew their individual and collective opposition to Congressional attempts to force a federal hospitalization program into the national Social Security System.

Richard Nelson of Chicago, a field representative for the American Medical Association, asked the Fourth Annual Conference of Medical Officers to organize a statewide effort against passage of the Forand Bill.

Mr. Nelson spoke to the county association representatives during a session held Sunday February 28, at the Columbia Hotel. Approximately 35 physicians representing unfortunately only six of the state's county societies attended.

The AMA field representative pointed out that Congressional proponents of the Forand legislation—labeled a "backdoor to socialized medicine"—are making a concerted effort for passage.

Mr. Nelson outlined a seven-point program which he said doctors and medical associations should follow in combatting Forand legislation.

The steps included the revision or updating of association resolutions opposing the Forand Bill and stating specific objections; the writing of at least one letter by every doctor to his congressman opposing the legislation; requesting civic, business and political leaders to write their congressman opposing the bill; asking other organizations such as hospital trustees, medical staffs, dentists, pharmacists and nurses to write opposition letters; and attempting to obtain editorial comment in local newspapers opposing the Forand Bill.

Mr. Nelson handed prepared copies of the opposition program to delegates attending the meeting. Copies are available to all societies through the South Carolina Medical Association headquarters at Florence.

Earlier, Dr. Joseph P. Cain, Jr., of Mullins, president-elect of the State Association, reviewed the role of county societies in the program of state and national organized medicine.

The Mullins physician said he regretted that "only six or seven counties are represented here today" and added that only interest and action at the local level would assure the success of State and AMA programs.

"It is most important that you attend meetings during the entire year," he said. "It is at the local meetings that the basic decisions are made."

"You have no business," he said, "criticizing what is handed down from the AMA and the State Association unless you have attended your county society meetings."

Dr. Cain said that American medicine "starts in Marion County and Horry County and Pickens County. It starts on the local level and it is only by action on the local level that we can succeed in our programs."

Dr. J. I. Waring of Charleston, chairman of the

Committee on Public Relations and Editor of the *Journal of the South Carolina Medical Association*, reported that it is still somewhat difficult to obtain papers for the *Journal*. He urged physicians to contribute their work and asked that local societies forward items of interest for publication in the *Journal*.

Dr. Waring called on Mr. Hoke May of the Association's public relations firm, Tobias & Company, to review the series of television panels which were inaugurated late last year.

Mr. May reported that four panels have been held to date—two at Charleston, one at Greenville and one at Columbia. All have met with excellent response from physicians and the community. Other panels are planned imminently at Florence and Spartanburg. The Charleston series has been put on a regularly monthly basis and a monthly schedule is promised by stations serving Greenville.

Mr. May explained that the program, informal discussion titled "House Call," is designed to offer the public basic educational material in several socio-economical-medical fields in which organized medicine is vitally interested.

Subjects discussed on "House Call" thus far include problems of the aged and food fads. A third script dealing with the rising costs of hospital care has been prepared by Tobias and Co.

The television time is being donated by stations as a public service, Mr. May said, adding that scheduling has been slow because in some cases it has been difficult to obtain panels of physicians.

He urged doctors to participate "as your contribution to the cause of medical public relations" and added that an extension of the program is now under way. The new step is the formation of a local speakers bureau to take the message of medicine before community, civic and fraternal organizations.

Mr. May said basic speech material will be supplied to all local medical societies. He added that civic clubs, especially, would be delighted to have their community physicians address them on the vital problems which are confronting American people in medical and medical-related fields.

During the busy afternoon schedule, physician-delegates heard reports from Charles N. Wyatt of Greenville, chairman of the Council—the executive committee of the State Association; Dr. J. Howard Stokes of Florence, treasurer of the State Association; William Sandow, Jr., executive director of the South Carolina Hospital Service Plan and the South Carolina Medical Care Plan.

Dr. Frank C. Owens of Columbia, chairman of the Committee on Legislation and Public Policy, reported that the "Blood Bank Bill" which would require segregation of Negro and white blood is dangerously close to passage. It has passed the State House and currently is before the Senate.

He said that steps were being taken to block passage of the bill which would seriously hamper the state's blood supply through the regional Red Cross

program. And he urged doctors to voice their personal opposition to their county senators.

The immediate past president of the Florida State Medical Association, Dr. Jere W. Annis of Lakeland, closed the meeting with a stirring address on the responsibilities of county medical society officers.

A text of his opening remarks is printed elsewhere in this issue. A tape recording of his outspoken address to the last Florida Medical Association meeting may soon be obtained through the State Headquarters at Florence.

WHAT YOU CAN DO ABOUT THE FORAND BILL

Local Society Work Sheet

You are familiar with the kit entitled "Aging is a Community Responsibility". This work sheet is a simplified action program which we urge you to follow step by step.

I. If you do not now have a local committee of doctors to fight the Forand Bill, we urge you to appoint one immediately. This committee should have the responsibility for accomplishing the following objectives:

A. Prepare every physician to write his congressman stating why he opposes the Forand Bill. This can be accomplished by showing the Dr. Orr audio-visual and by distributing copies of the AMA pamphlet "The Forand Bill—What You Should Know About It". These can be obtained through your state medical society.

B. Internal Resolutions

Get a current resolution from your local medical society stating why the group is opposed to the Forand Bill. (Some medical societies have passed resolutions against the bill; however, these should be *updated* and again directed to the congressman).

RESOLUTIONS ARE NEEDED NOW

1. Effective Use of Resolutions

- Prepare six copies of the local medical society resolution.
- Send a copy to your congressman with a letter of transmittal asking that he use his influence with the House Ways and Means Committee to keep this bill from being reported.
- Send a copy to each of your U. S. senators with a similar letter of transmittal.
- Send a copy of the resolution to Wilbur Mills, Chairman, House Ways and Means Committee, House Office Building, Washington 25, D. C.
- Send two copies to your state society headquarters.

C. Member letters

Every doctor should send at least *one* letter to his congressman covering the following:

- State opposition to the Forand Bill.

- Cite reasons for opposition.

- Point out instances how the aged are being cared for in your community.

- Urge his congressman to contact the members of the House Ways and Means Committee.

D. External Resolutions

Your local medical society should get *at least ten resolutions* in your area opposing the Forand Bill from the following groups:

- Hospital Boards of Trustees
- Hospital medical staffs
- Dentists, Pharmacists, Nurses, and others as indicated on the attached list.

These resolutions should be handled in the same manner as described previously.

E. External Letters

Each doctor should have at *least ten non-medical associates* write letters to their Congressman opposing the Forand Bill. This group should include:

- Local government officials such as the county sheriff, county judge, state legislator, mayor, etc.
- Local business and community leaders such as bankers, industrialists, editors, insurance executives, ministers, hospital administrators, etc.
- Leaders of various local business and professional groups such as Chamber of Commerce, Bar Association, civic clubs, nursing profession, senior citizen groups, etc.

F. Make certain that the local medical society auxiliary is well informed and prepared to do the following:

- Pass a resolution similar to the one described for the county medical society and distributed in the same manner.
- Get five resolutions from various women's groups in the county. (See attached list for suggestions).
- Have every member of the Auxiliary write her Congressman stating why she opposes the Forand Bill.
- Have every member of the Auxiliary ask five personal acquaintances to write their Congressman expressing opposition to the bill.

G. Editorial Comment

For the purpose of obtaining a favorable editorial comment, this local committee should meet with the editors of the local papers to express Medicine's position on the Forand Bill and to explain what is being done to solve the problems of the aged locally. A copy of all local editorials should be sent to your state medical society office.

Suggested List of Local Organizations to Contact
For Resolutions Opposing Forand Bill

Chamber of Commerce
 Junior Chamber of Commerce
 Bankers Association
 Insurance Agents Association
 Bar Association
 Dental Society
 Pharmaceutical Association
 Retail Drug Association
 Hospital Board of Trustees
 Hospital Medical Staff
 County Nurses Association
 American Legion
 Veterans of Foreign Wars
 Amvets
 Farm Bureau
 Veterinarians Medical Association
 Grange
 Parent-Teacher Association
 Ministerial Alliance Association
 Medical Assistance Association
 Medical Technicians Association

Service Clubs, e. g., Rotary, Kiwanis, Lions
 Fraternal Societies, e. g., Masons, Shriners, Knights
 of Columbus, Woodmen of the World, Odd Fellows
 City Council
 County Board of Supervisors, e. g., Fiscal Courts
 Nursing Homes
 Certified Public Accountants Association
Suggested Women's Organizations
 Woman's Committee, County Farm Bureau
 Home Demonstration Clubs
 League of Women Voters
 American Assn. of University Women
 Business and Professional Women's Club
 Garden Club
 Federation of Teachers
 Federation of Women's Clubs
 Eastern Star
 Hospital Auxiliary
 The National Secretaries Assn., local chapter
 Homemakers Club
 Women's Church Societies



BLUE CROSS . . . BLUE SHIELD



Prepayment for Prolonged Illness— the South Carolina Blue Cross-Blue Shield Answer

All the problems occasioned by a prolonged illness cannot be resolved in terms of medical treatment alone, since they also include questions of finance. For those who can, in any measure, pay for health care, the extension of voluntary prepayment would appear to be the most desirable method of paying the cost of long-term illness. The potential of voluntary prepayment as a method of financing health care cannot be fully realized unless basic plans are extended to meet the actual cost of prolonged illness care and treatment.

National Health Care Costs

Through an examination of the pattern of national health care expenses, the need for voluntary prepayment expansion becomes evident. Expenditures for health needs continue to constitute a little more than 4 per cent of average individual earnings. In other words, the health care bill and the cost of living have been increasing proportionately over the last several years. However, because of the unexpectedness and extent of serious illness on the part of certain individuals, the total amount of expense making up the 4 per cent is most inequitably distributed. A quote from a Health Information Foundation Bulletin illustrates the point.

"Major or catastrophic charges, i. e., charges of \$500 or over, were incurred by 27 per cent of the

families receiving any voluntary health insurance benefits. Within this group, more than half had charges falling within the range of \$500-\$750; one-fifth had charges of over \$1,000."

Prepayment (budgeting) for health care has become a universal means of preventing embarrassment and financial ruin for American families. These families, however, are not nearly so completely protected or as safe from economic catastrophe as they assume when they purchase health insurance. This is indicated by the fact that, of the total health care bill amounting to \$19 billion, only 15 per cent is covered by any form of prepayment. This means that American families must pay out of pocket \$15 to \$16 billion a year for health care. Such an amount certainly creates collection problems on the part of the providers of services and disappointment on the part of the partially prepaid public with its insurance. It is noteworthy that even hospital bills are only 50 per cent covered, and physicians' services only 13 per cent covered. The latter is somewhat higher, of course, for physicians' services rendered in hospitalized cases.

In the two areas of hospital care and physicians' services rendered in the hospital, Blue Cross-Blue Shield do a much better job than other prepayment mechanisms. Blue Cross covers an average of 75 to 80 per cent of the hospital bill, and Blue Shield about two-thirds of physicians' services in the hospital. Blue Cross and Blue Shield are doing a good, even excellent, job in the areas where they operate. One

of the main reasons for this better coverage is the Blue Plans' basic principle of providing and paying for the services actually required and not limited dollar indemnities. It should be noted in passing, however, that the service benefit principle entails a somewhat higher price level than other methods, since it directly reflects the total cost of services covered. Operating in an era of increasing costs, service benefit prepayment plans must increase the price at a proportionate rate. Even commercial companies with their dollar-limited liability have not entirely escaped the squeeze of spiraling prices and buyer resistance.

Coverage for More Expensive Illnesses

Thus far three possible approaches to the complex problem of increased cost, increased usage, and competition in the health care field have emerged. They are:

1. *An all inclusive approach with presumed internal economic controls.* The commercial Major Medical expense policy is a typical example. This method says that any family should be able to provide for its own health needs to some extent and that, further, as prepayment dollars are used to provide care, the subscriber or policyholder should expect to pay some minor portion as the bills increase. This is the philosophy behind the deductible of \$50 or \$100 or \$200, and the co-insurance of 20 or 25 per cent. Commercial insurance "major medical expense" plans are usually identified by these two features of "deductibles" and "co-insurance." The "deductible" amount is that sum of initial medical expense which an insured person must pay before his policy benefits begin.

The sum varies according to the provisions of the particular policy. The insurance company then pays a percentage (usually 75 per cent) of the remaining medical bills, the insured paying the balance. Major medical expense policies are used either as a supplement to basic hospital, surgical, and regular medical expense insurance already in existence, or as a "comprehensive, integrated" protection whereby the major medical plan includes the basic coverages. Where major medical supplements, the "deductible" appears as a "corridor" between the basic plan and the major medical. Where the "comprehensive" approach is used, there is an initial "deductible" upon any covered benefits with "co-insurance" thereafter.

2. *The all-inclusive approach without controls or limit.* This approach says that all health care needs, regardless of place of occurrence or type of service, should be covered by prepayment dollars. This is the basic idea of socialized medicine and is strongly advocated by unions and other social-welfare oriented groups. The basic fact, which this approach ignores, is that people in general cannot afford as much health care as they might desire. A simple and parallel illustra-

tion is the case of Joe Doakes whose friend offers to pay for a car for him with no strings attached. Joe will undoubtedly pick out a somewhat higher priced automobile than if he were paying for it himself. In health care prepayment, as in any other contractual arrangement involving financial consideration, there must be some controls if the program is to be helpful to a majority of people.

3. *Inclusive services on a selective condition basis.* This approach is essentially limited to Blue Cross-Blue Shield principles. That is, that there should be good and adequate coverage when most needed, with built-in controls against misuse of the program. This assumes mature understanding of all participants in the program and an acceptance of responsibility in exercising the prerogatives of use. It should be mentioned that one of the basic insurance principles for any type of risk is that the occurrence of the hazard insured against is beyond the control of the insured. In health insurance, this principle is becoming more often violated.

Initially, Blue Cross-Blue Shield was successful in fighting a delaying action against Major Medical and comprehensive coverage by using the service benefit principle and, through the co-operation of the providers of health services, in maintaining adequate coverage for an enlightened public in an expanding economy. However, the Blue Plans recognize the need for expanding the *scope* of prepaid health care; that is, the health services other than those rendered in the hospitalized case. This category of services makes up almost 80 per cent of the total public health bill. Although Major Medical encompasses this "other" 80 per cent, the co-insurance and deductible features are disadvantages, since they do not prevent economic hardship for the individual family hit by a big bill; they tend to inflate rapidly the cost of health care, and have proven to be questionable aids in controlling use. An executive of a large insurance company, which has actively promoted major medical coverage, recently stated that perhaps a monstrosity had been created in this sort of coverage. Although the reluctance on the part of individuals to prepay for health care is a deterrent to expanding benefits, it is not an insurmountable obstacle. As costs continue to increase and more and more people experience big bills, the realization of the need for breadth and depth of coverage increases.

The Best Method

The Prolonged Illness Coverage presently being offered by the S. C. Blue Cross and Blue Shield Plans was designed to meet best the needs of a majority of subscribers and at the same time to include certain necessary controls which are either absent or ineffective in the commercial coverages. The first article of the Prolonged Illness Contract^o best describes the scope and intent of the coverage. It says:

^oSee new supplement to Blue Shield *Participating*

Physician's Manual for details of benefits and conditions covered.

"The benefits described in this certificate of contract are in addition to those provided in the basic SCHSP and SCMCP certificates of contract under which the subscriber and his dependents are enrolled. These benefits include additional days of care to those provided by the basic contracts as well as physicians' and related care for these additional days and for care in institutions other than general hospitals for certain illnesses and conditions specified in the contract."

It should be noted that the coverage described above has no over-all "deductible," "corridor," or "co-insurance." The necessary controls are accomplished by specifically listing in the contract the general categories of conditions and illnesses which are covered, and which will include practically all of the real prolonged and expensive cases.

One of the criticisms which has been leveled at this approach is that the contract would better indicate what conditions are *not* covered. Even if all the diagnoses not covered were listed, the picture of what PIC is designed to do would still be unclear. Aside from the multitude of illnesses which are amenable to direct and short-term treatment, and therefore adequately covered by the basic contracts, there seem to be three classifications of the more uncommon and prolonged group of conditions. First there is the very difficult kind of cases such as those with multiple fracture occurring as the result of accidents. By persistent and specialized treatment and care, these cases can be completely cured. The second group includes some diseases for which there is really no sure and permanent cure, but which may be arrested or significantly slowed by direct and continuous treatment and diagnostic checks. One of the best examples in this category is tuberculosis. The third group consists of those afflictions such as arthritis and arteriosclerosis which may cause all kinds of difficulty, and will, in most instances, hasten death. These types of diseases are not susceptible to direct treatment, and, in fact, do not require other than minimum care and perhaps personal assistance. If there is no pain, as with parkinsonism resulting from advanced arteriosclerosis; or if the pain cannot be satisfactorily relieved for long periods of time, or cannot be measurably alleviated by therapy, as in the case of arthritis, the general well being of the patient is more closely related to his own attitude than to specific treatment.

The basic tenets of Prolonged Illness Coverage include an effort to provide payment for medical services in cases of long duration involving great expense; where there is some expectation of cure or improvement so that the patient may be made well enough to be productive in society. This means the application of really constructive medical and related services where the illness or condition can be cured or at least where the progress of the disease can be slowed or arrested. There is no intent to provide anything resembling custodial or domiciliary care

in cases which will progressively deteriorate and the prognosis can be none other than poor. Any program of care, in such cases, if prepaid, would likely be instituted simply for psychological reasons or in desperation.

In an effort to keep this coverage broad in its potential, some parts of the contract must be left very general with the expectation that there will be a willingness to treat specific situations on their merits by all parties concerned. At the same time, certain general controls are needed which will prevent the development of a whole pattern of custodial care on the part of providers of medical and related services. Based on these principles, it seems reasonable that the first two general classifications of conditions outlined above could and should reasonably be covered under any type of Prolonged Illness Coverage. Just as definitely, the third class has no place in this particular prepayment plan. By and large, the welfare and general health of people with these chronic, progressive, and presently incurable ailments depends more on their own attitude, personal regimen, and self-dependence, than on any scientific approach to diagnosis and treatment.

Summary

Although health care expenses, on the average, represent only a minor portion of individual incomes, some unfortunate families find their share staggering, even ruinous, financially. There is a demonstrated need for voluntary prepayment methods to extend coverage both upward and outward to include long periods of hospitalization and attendant physicians' services as well as the care and services needed during long periods of convalescence. Essentially three ways of approaching the problem are currently being used:

1. The all-inclusive illnesses approach with "deductibles" and "co-insurance" as deterrents to over-use.
2. The completely comprehensive approach which assumes there can be enough funds made available through the payment of small amounts to meet the lesser number of large withdrawals without any direct expense on the part of the individual at the time of need.
3. The Blue Cross-Blue Shield method which provides any needed services without over-all deductible or co-insurance for selected groups of conditions and illnesses.

The first method, although successful in extending coverage, does not prevent economic hardship in most cases and tends to encourage inflation of health care costs. The second method will encourage people to seek more care more often than they can afford or are willing to support. The eventual resolution of this problem is socialized medicine. The third approach—that of the Blue Plans—provides viable extension of the prepayment mechanism to match the extension of services in those cases which are of greatest duration, most expensive, and which are most subject to cure or definite control through medical treatment.

NEWS

BEAUFORT

A Beaufort physician has been re-elected a trustee of the National Jewish Hospital at Denver, Colo. Dr. Sol Neidich was returned to office at the medical center's recent annual meeting.

The non-sectarian hospital specializes in the treatment of tuberculosis and other chest diseases, including heart defects amenable to surgery.

DR. W. S. LYLES

Dr. William S. Lyles of Winnsboro, S. C. has been certified by the American Board of surgery as a diplomate. He was notified on Thursday, January 28th, by the Board, following a written examination taken in Atlanta, Ga., in December and an oral examination in Winston-Salem, N. C., on January 19.

Dr. Lyles holds a Fellowship in the American College of Surgeons, and has recently been reappointed as Chief of Staff at the Fairfield County Memorial Hospital. His certification as a diplomate is in the field of Medical Surgery.

DR. JOSEY HEADS SOCIETY OF INTERNAL MEDICINE

Dr. A. Izard Josey of Columbia has been elected president of the South Carolina Society of Internal Medicine.

Other officers elected in a recent meeting at the Medical College Hospital, Charleston, S. C. are Dr. R. Cathcart Smith of Conway, vice president; Dr. Ralph R. Coleman of Charleston, secretary and treasurer.

The organization, which is a component society of the American Society of Internal Medicine, is composed of internists in the state whose practice is limited to internal medicine.

Several scientific papers were given during the meeting by doctors H. R. Pratt-Thomas, John Buse, W. M. McCord and James A. Richardson.

MEDICAL SCHOOL GETS NEW DEPT. OF PSYCHOLOGY

The Medical College of South Carolina has established a division of clinical psychology in the department of psychiatry.

The new division went into operation recently.

It was made possible by a grant recently approved by the South Carolina State Agency of Vocational Rehabilitation. The grant of \$10,500 matched, on a 70-30 basis, a grant of \$4,500, made in November by the Saul Alexander Foundation.

These funds will entirely support the clinical psychology division during the first year of operation. After that, the division is expecting to be self-supporting.

The division will be called the Saul Alexander Division of Clinical Psychology, and will be headed

by J. M. Rowe, a psychologist formerly associated with the Charleston County Mental Health Clinic.

During the first year, the division will be primarily concerned with working with patients under the vocational rehabilitation program.

MOVES OFFICE

Dr. W. Samuel A. Harris has moved into new offices opposite Howard Johnson's Motor Lodge on North Kings Highway at Myrtle Beach, S. C. The newly renovated office will consist of a reception room, six therapy, x-ray, laboratory, and examining rooms, and Dr. Harris' consultation room.

DR. BURNSIDE TO JOIN FATHER IN PRACTICE

Dr. A. F. Burnside, Jr., has announced that he will join his father, Dr. A. F. Burnside, Sr., in practice of general surgery.

Their offices are located at 3001 Blossom Street, Columbia, S. C.

Dr. Burnside was chief of surgery at Zaragosa, Spain, at a Strategic Air Command Base and also worked for several months at the USAF Hospital at Torre Jon Air Base at Madrid.

A graduate of Dreher High school in 1945, he immediately entered Yale University for his pre-medical training. He finished in 1948, and then entered the South Carolina Medical College at Charleston. He finished at the Medical College in 1952.

Having completed three years at the Medical College, Dr. Burnside in the summer of 1951 worked in the Department of Surgical Pathology at the Mayo Clinic at Rochester, Minn.

Upon completion of his work at Charleston, Dr. Burnside interned at Philadelphia General Hospital for 14 months. He then entered a fellowship in General Surgery at Mayo Clinic and was there for four years of specialized training and work.

In late 1957, he entered the Air Force. Following a six-weeks course for Air Force Medical officers at Gunter Field, Montgomery, Ala., Dr. Burnside went directly to Spain.

MCCORMICK GROUP LOOKS FOR DOCTOR

Mayor Thomas B. Minor has appointed a committee of five citizens to investigate the possibility of encouraging a second physician to locate in McCormick.

There is only one doctor serving the more than 10,000 residents of the county.

Mayor Minor yesterday praised the work of Dr. Sumner W. Brown during a recent influenza outbreak. He said Dr. Brown is to be commended for his work, but that another physician is needed in the county.

A number of local citizens last year spoke to several doctors and at least one visited to look over the situation.

Mayor Minor says the main objection doctors have

to locating here is that there is no clinic or hospital. The nearest hospital is located at Greenwood, 23 miles away.

DR. LIND HONORED BY HOSPITAL STAFF

Dr. S. C. Lind, retired physician now making his home in Myrtle Beach, was honored by the professional staff of Ocean View Memorial Hospital recently with a testimonial dinner at the Dunes Golf and Beach Club.

A handsome plaque was presented to Dr. Lind by Dr. Gabriel P. Joseph, chief-of-staff of the Hospital on behalf of the local medical profession.

Dr. Lind was instrumental in the organization and design of Ocean View Memorial Hospital. He offered his professional services and advice to the hospital as a personal contribution to the vital civic improvement. His personal contribution to the organization and initial operation of the hospital was recognized by the professional staff of the institution at the testimonial dinner.

Dr. Lind continues to be active in the affairs of the Hospital in an advisory capacity.

DR. SIMS IS "YOUNG MAN OF YEAR"

Dr. William E. Sims, Jr., was honored this week as Lancaster County's "Young Man of the Year."

The Lancaster Junior Chamber of Commerce so honored Dr. Sims at its annual Ladies' Night banquet, held at the Lancaster Golf Club.

Dr. Sims, a Greenville County native, was graduated from Furman University and the Medical College of South Carolina. He has made his home in Lancaster since he began his practice.

ORANGEBURG NAMES DR. ATWILL "YOUNG MAN OF YEAR"

Dr. J. Harvey Atwill has been designated by the Orangeburg Junior Chamber of Commerce as "Outstanding Young Man of the Year for 1959."

Dr. Atwill, radiologist at Orangeburg Regional Hospital, was honored at a meeting of the Orangeburg Junior Chamber.

A Florence native, he was graduated from the University of South Carolina and the Medical College of South Carolina. He interned at the Jersey City Medical Center, and served a three-year residency in radiology at Roper Hospital. He is a member of the American College of Radiologists, a director of the S. C. Cancer Society, a member of the board of the Orangeburg Community Concert Association, lay leader of St. Andrew's Methodist Church and president of the Orangeburg Rotary Club.

MEDICAL COLLEGE TO GET \$7,500 FROM UNITED FUND

The United Fund Medical Research Program has announced that the Medical School in Charleston, will receive \$7,500, marked as unrestricted funds for basic medical research this year.

Dr. Ben Miller, chairman of the Medical Research Program says, "This fund is raised in principle through the nation-wide United Funds with our local United Fund participating. This has allowed our communities' cooperative givers to donate in a systematic way moneys for basic research."

The Medical School at Charleston will have full control of the grant and may use it where the medical board deems most important. The fund may go toward one or many research projects. Nationally and locally many programs are carried on to support individual or specific diseases. This simply spotlights the importance of basic research.

Dr. Thomas A. Collins, pediatrician, has moved his office from Duckett Circle to his own building at 502 E. Greenville Street, Anderson, S. C.

DR. WM. CHEEZEM INDUCTED INTO SURGEONS GROUP

Dr. William L. Cheezem, Jr., of Marion, S. C. was inducted recently in the Fellows of the American College of Surgeons.

WELCOMED HOME

Walterboro, S. C. has obtained the services of two new doctors. Dr. Curtis Percy and Dr. Luke Erwin, both of Walterboro, have recently opened offices there.

DEATHS

DR. C. M. TEMPLETON

Dr. Clinton M. Templeton, 47 of North Augusta, S. C. was found dead aboard a grounded cabin cruiser in Clark Hill Lake, near McCormick, S. C. on February 28. Dr. Templeton apparently died of natural causes.

A graduate of the University of Georgia Medical School, he was past president of the Richmond County Medical Association and has served as a lieutenant colonel in the U. S. Army Medical Corps in World War II.

DR. EUGENE THOMASON

Dr. Eugene Thomason of Fountain Inn, aged 35, was killed when his home was swept by fire February 25th.

Firemen discovered Dr. Thomason's body. The coroner said the body was not burned badly and death apparently was due to suffocation.

DR. L. A. RISER

Dr. Luther Allen Riser, 82, of 828 Woodrow St., died at the Columbia Hospital.

He was born in Newberry and was a graduate of Newberry College and the Medical College of the University of Maryland. He was the first public health

officer in South Carolina and set up the State Board of Health County Unit under the Rockefeller Foundations. He was director of the County Health Unit for a number of years.

He organized the Bureau of Vital Statistics of the State Board of Health. He was associated with the Pilot Life Insurance Co., of Greensboro, N. C., and was a representative of the Life Extension Institute. Prior to his retirement, he was associated with the Veterans' Administration.

DR. M. P. YOUNG

Dr. Mason P. Young, 72, of Anderson, died February 6th at the Anderson Memorial Hospital after two days illness.

He was a member of the American College of Physicians, as well as state and county medical societies. He graduated from the Jefferson Medical School. He went to China in 1916 as a medical missionary, where he served for 33 years.

Survivors include his daughter, Dr. Josephine Sullivan of Greer and his brothers, Dr. J. R. Young and Dr. C. H. Young of Anderson.

DR. R. W. RAY

Dr. Roy William Ray, Jr., 33-year-old resident in anaesthesiology at the Medical College of South Carolina was found dead in his apartment February 11, in Charleston, S. C.

Dr. Ray was a native of Atlanta and a 1953 graduate of the University of Georgia Medical College.

DR. J. A. MILLSPAUGH

Dr. Judson A. Millspaugh, 56, of St. George died of a heart attack March 4 in Port Wentworth, Ga., en route to Miami.

ANNOUNCEMENTS

South Carolina Society of Pathologists has elected the following officers for the year 1960 (except as indicated).

President: E. Arthur Dreskin, 100 Mallard Street, Greenville, South Carolina.

Vice President: McKenzie P. Moore, Medical College of South Carolina, Charleston, South Carolina.

Assemblyman to CAP (1961): DuBose Dent, Baptist Hospital, Columbia, South Carolina.

Councilor to the ASCP (1961): D. James Greiner, McLeod Infirmary, Florence, South Carolina.

Secretary-Treasurer: Michael F. Patton, Spartanburg General Hospital, Spartanburg, South Carolina.

PUBLIC HEALTH ASSOCIATION

The 37th Annual Meeting of the S. C. Public Health Association will be held May 12-14 at Myrtle Beach, S. C. Speakers for both the General Sessions and the Section Meetings include persons well in-

formed on their chosen subjects. The theme of the meeting is "Public Health—What, Why and How". Convention headquarters will be the Ocean Forest Hotel.

The Section of Ophthalmology and Otolaryngology of the Southern Medical Association announces that they are now accepting papers by physicians of either specialty living in the area of the Southern Medical Association for consideration for presentation at the next annual meeting to be held in St. Louis, Missouri from October 31 to November 3, 1960.

The paper or an abstract of the paper may be sent directly to the Secretary, Dr. Albert C. Esposito, Suite 1212, First Huntington National Bank Building, Huntington, West Virginia as soon as possible.

SIX OPHTHALMOLOGY RESIDENCY FELLOWSHIPS ARE ANNOUNCED

Six additional Fellowships for Residents in Ophthalmology, to be awarded July 1, 1960, have been announced by the Guild of Prescription Opticians of America, Inc., through its President, William T. Heimlich, of Ithaca, N. Y. Applications for these Fellowships must be received by May 15, 1960.

Each Fellowship is for a total of \$1,800, payable in monthly stipends over the period of a three-year Residency. The grants are limited to Residencies at approved institutions where full three-year Residencies are offered, but residencies which begin anytime during the calendar year are eligible. Application forms and covering information are available by writing to FELLOWSHIPS, Guild of Prescription Opticians of America, Inc., 110 East 23rd Street, New York 10, N. Y.

The six new Fellowships being granted represent one for each of the six areas into which the United States and Canada have been divided upon the basis of a nearly-equal number of eligible Residencies in each area.

The Guild provides all Fellowship funds as well as the program's cost of administration but the selection of the Resident Fellow is made by a Committee of Ophthalmologists in each area.

NINTH ANNUAL POSTGRADUATE SEMINAR FOR PEDIATRICIANS

Neurologic Disturbances in Infants and Children

Department of Pediatrics

Temple University School of Medicine
at

ST. CHRISTOPHER'S HOSPITAL
FOR CHILDREN

2600 North Lawrence Street

Philadelphia 33, Pennsylvania

May 25, 26, 27, and 28, 1960

THIRD INTERNATIONAL CONGRESS OF PHYSICAL MEDICINE

The Third International Congress of Physical Medicine will be held August 21-26, 1960 inclusive, at The Mayflower, Washington, D. C.

The preliminary prospectus covering the international conference carries in detail information on registration, application to present a paper, a scientific exhibit, a scientific film, etc. A copy of this preliminary program may be had on request by writing: Dorothea C. Augustin, Executive Secretary, Third International Congress of Physical Medicine, 30 N. Michigan Avenue, Chicago 2, Illinois.

The Department of Maternal and Child Health of the Harvard School of Public Health announces the availability of two Fellowships for the academic year 1959-1960, to be granted to physicians who wish to work for a Master of Public Health degree or other advanced degree in Public Health, with specialization in Maternal and Child Health. These Fellowships are made available to the Harvard School of Public Health by the Charles H. Hood Dairy Foundation, and the Massachusetts Department of Public Health which administers a grant for this purpose from the Children's Bureau, U. S. Department of Health, Education, and Welfare.

Candidates for these Fellowships should be graduates of an approved School of Medicine and, in addition, should have:

- A. Completed or be in process of completing the residency requirements for certification by the American Board of Pediatrics or the American Board of Obstetrics and Gynecology, and give evidence of potentialities for satisfactory achievement in positions of administration, or teaching and field research; or
- B. Had specialized hospital training in pediatrics or obstetrics and experience in some aspect of a maternal and child health program, including school health or services for crippled children, preferably for at least a combined total of three years in training and experience.

Exceptionally, consideration may be given to candidates who do not fulfill these requirements.

The Fellowships will cover tuition and fees at the Harvard School of Public Health, and allowance for travel necessary in connection with the studies, a monthly stipend of \$400 for maintenance during the period of actual study, and an additional \$30 a month for each dependent.

Inquiries about these Fellowships should be sent promptly to Dr. Martha M. Eliot, Professor of Maternal and Child Health, Harvard School of Public Health, 55 Shattuck Street, Boston 15, Massachusetts, certainly before July 1, 1960. Application forms for admission to the School of Public Health and a catalogue of courses may be obtained from the Dean of Admissions at the same address.

The Duke University School of Medicine is again offering doctors a chance to combine postgraduate study with an overseas vacation by sponsoring its fifth medical seminar cruise.

This year's Duke cruise will take doctors to the Baltic, visiting Le Havre, Cuxhaven, Leningrad, Helsinki, Stockholm, Copenhagen, and Hamburg. The cruise ship, "T. S. ARIADNE," which will sail from Wilmington, N. C. on June 5 and from New York City on June 8, will terminate in Hamburg, Germany, on June 28. Some of the doctors will remain in Europe for further vacationing, while others will return immediately to the United States by ship or air.

Shipboard lectures will be given on various subjects in medicine, pediatrics and thoracic surgery. The faculty will be composed of members of the Duke staff. Arrangements are also being made for lectures in the medical centers at Leningrad, Helsinki, Stockholm, and Copenhagen.

The medical program has been approved by the American Academy of General Practice for Category I Credit.

Write to:

W. M. Nicholson, M. D.
Professor of Medicine and
Assistant Dean in Charge of
Postgraduate Education
Duke University Medical Center
Durham, North Carolina

WANTED: Male psychiatrist; Diplomate or with three years approved training; to join group practice 145-bed approved psychiatric hospital. Salary: \$15,000-\$18,000 first year; \$20,000-\$25,000 second with incentive factor. Write Box A care this Journal.



DR. WILLIAM WESTON, JR.
PRESIDENT
AND DELEGATE TO A. M. A.



DR. JOSEPH P. CAIN
PRESIDENT-ELECT



One Hundred and Twelfth Annual Session

SOUTH CAROLINA MEDICAL ASSOCIATION

May 17, 18, 19, 1960

OCEAN FOREST HOTEL

Myrtle Beach, S. C.

GENERAL PROGRAM

TUESDAY, MAY 17

- 9:00 A. M.—Meeting of Council
- 2:30 P. M.—House of Delegates (Ball Room)
- 5:30 P. M.—Meetings of Reference Committees

WEDNESDAY, MAY 18

- 9:30 A. M.—House of Delegates Resumes (Ball Room)
- 11:00 A. M.—Scientific Film (TV Room)
- 12:15 P. M.—Adjournment Sine Die
- 12:30 P. M.—Alumni Luncheon (Main Dining Room)
- 2:00 P. M.—Scientific Session (Ball Room)
- 9:00 P. M.—Alumni Association Entertainment (Ball Room)

THURSDAY, MAY 19

- 9:00 A. M.—Scientific Session Resumes
- 12:30 P. M.—Luncheon Recess
- 2:00 P. M.—Scientific Session Resumes
- 5:30 P. M.—Adjournment
- 8:00 P. M.—Annual Banquet and Ball for Alumni Association and Guests

HOUSE OF DELEGATES

Dr. William Weston, Jr., Presiding

TUESDAY, MAY 17

- 2:30 P. M.—Call to Order
 - Invocation
 - Report of Credentials Committee
 - Opening Remarks by the President
 - Introduction of President-elect
 - Announcement of Reference Committees
 - Presentation of Resolutions and Recommendations
- 3:15 P. M.—Introduction of Officers and Guests of Woman's Auxiliary
 - Reports of Officers
 - The President
 - The Executive Secretary
 - The Secretary
 - The Treasurer
 - The Editor of the Journal
 - The Chairman of Council
 - The Delegate to the A. M. A.
 - Reports of Committees

(The reports of the Committees will have been published in the Journal and will not be read before the House. Any supplementary remarks by the Chairmen will be heard at this time.)

Report of State Board of Medical Examiners

Report of Executive Committee of State Board of Health

Unfinished Business

New Business

4:30 P. M.—(Special Order). The Annual Meeting of the Corporation, The South Carolina Medical Care Plan

5:30 P. M.—Meetings of Reference Committees

(All members of the Association are invited to appear before the Committees considering matters in which they are interested. Meeting places will be announced.)

WEDNESDAY, MAY 18

9:30 A. M.—Call to Order

Reports of Reference Committees

11:30 A. M.—Annual Elections

Officers:

President-Elect

Vice-President

Secretary

Treasurer

Delegate to the A. M. A.: (2-yr. term)

(The term of Dr. George Dean Johnson expires December 31, 1960)

Alternate Delegate to the A. M. A.: (2-yr. term)

(The term of Dr. Charles N. Wyatt expires December 31, 1960)

Councilors: (3-yr. terms)

First District (The term of Dr. Baehman S. Smith, Jr. expires)

Fourth District (The term of Dr. Charles N. Wyatt expires)

Seventh District (The term of Dr. A. C. Bozard expires)

Members of Mediation Committee: (3-yr. terms)

First District (The term of Dr. John A. Siegling expires)

Fourth District (The term of Dr. Thomas G. Goldsmith expires)

Seventh District (The term of Dr. S. E. Miller expires)

Members of the State Board of Medical Examiners: (4-yr. terms)

At Large (The term of Dr. Harold E. Jerve, Jr. expires)

Sixth Congressional District (The term of Dr. Harold S. Gilmore expires)

Members of Hospital Advisory Council of State Board of Health (4-yr. terms)

(The term of Dr. Roderick Macdonald expires)

(The term of Dr. B. J. Workman expires)

Selection of Place for the 1961 Annual Meeting

Sine Die Adjournment

SCIENTIFIC SESSION
SOUTH CAROLINA MEDICAL ASSOCIATION
Myrtle Beach, South Carolina
May 18-19, 1960

WEDNESDAY, May 18th, 1960

Presiding: William Weston, Jr., M. D.

- 2:00 p. m. to 2:15 p. m. Griseofulvin, Kathleen Riley, M. D., Charleston, South Carolina.
- 2:15 p. m. to 2:45 p. m. *Symposium on Glaucoma*, J. Howard Stokes, M. D., in collaboration with:
 Roderick Macdonald, M. D.
 Thomas Gaines, M. D.
 Joseph Workman, M. D.
 Pierre Jenkins, M. D.
- 2:45 p. m. to 3:15 p. m. Aortic Valvular Disease, William H. Muller, M. D., Charlottesville, Virginia.
- 3:15 p. m. to 3:30 p. m. Intermission to view Scientific and Commercial Exhibits.
- 3:30 p. m. to 3:45 p. m. Presidential Address—William Weston, Jr., M. D.
 (1) The Present Status of the S. C. Medical Association and the Future of Medicine as Opposed to Socialized Medicine and (2) Rheumatic Fever.
- 3:45 p. m. to 5:15 p. m. *Panel discussion on Cardiovascular Diseases:*
 Edward F. Parker, M. D., Moderator
 *William H. Muller, Jr., M. D.
 Bruce Logue, M. D.
 Rhett Talbert, M. D.
- 5:15 p. m. to 5:30 p. m. Intermission to view Scientific and Commercial Exhibits.

THURSDAY, May 19th, 1960

Presiding: William Weston, Jr., M. D.

- 9:00 a. m. to 9:20 a. m. Pregnancy Following Operative Delivery, Robert Cosgrove, M. D., Jersey City, New Jersey.
- 9:20 a. m. to 9:45 a. m. Obstetrician's Responsibility in the Prevention of Neurologic Disease in Children, George W. Anderson, M. D., Providence, Rhode Island.
- 9:45 a. m. to 10:45 a. m. *Panel Discussion on Perinatal Problems:*
 Herbert Black, M. D., Moderator
 *George W. Anderson, M. D.
 Robert Cosgrove, M. D.
 Walter Hart, M. D.
- 10:45 a. m. to 11:00 a. m. Intermission to view Scientific and Commercial Exhibits.
- 11:00 a. m. to 11:30 a. m. Early Management of the Severely Burned Patient, Edward Kremenz, M. D., New Orleans, Louisiana.

*Participation sponsored by the South Carolina Heart Association.

*Participation sponsored by the Division of Maternal and Child Health, S. C. State Board of Health.

NOTE—This program has been authorized as acceptable for 9 hours credit under Category #1 by the Academy of General Practice.

- 11:30 a. m. to 12:30 p. m. *Panel Discussion on Hormone and Chemotherapy of Cancer:*
 Forde McIver, M. D., Moderator
 °A. R. Curreri, M. D.
 Edward Kremenz, M. D.
 Charlton deSaussure, M. D.
 Presiding: *Clay Evatt, M. D.*
- 2:00 p. m. to 2:30 p. m. The Hands in the Diagnosis of Rheumatic Diseases,
 Howard L. Holley, M. D., Birmingham, Alabama.
- 2:30 p. m. to 3:00 p. m. The Natural History of Arteriosclerosis Obliterans,
 E. V. Allen, M. D., Rochester, Minnesota.
- 3:00 p. m. to 3:30 p. m. Basic Psychotherapy, Kenneth Appel, M. D., Philadelphia, Pennsylvania.
- 3:30 p. m. to 3:45 p. m. Intermission to view Scientific and Commercial Exhibits.
- 3:45 p. m. to 4:00 p. m. Portal Hypertension and Bleeding Esophageal Varices,
 Randolph Bradham, M. D., Charleston, South Carolina.
- 4:00 p. m. to 5:30 p. m. *Panel Discussion on Geriatrics:*
 °°E. V. Allen, M. D., Moderator
 Kenneth Appel, M. D.
 Bruce Logue, M. D.
 Howard L. Holley, M. D.

°Participation sponsored by the American Cancer Society, South Carolina Division, Inc.

°°Participation sponsored by the Heart Disease Section, S. C. State Board of Health.

Scientific Program Committee:

Dr. Dale Groom, Vice-Chairman
 Dr. George Durst
 Dr. George Bunch
 Dr. Robert Wilson, Ex-Officio
 Dr. William Weston, Ex-Officio
 Dr. Wm. H. Prioleau, Chairman
 158 Rutledge Avenue
 Charleston, South Carolina



DR. CLAY W. EVATT
 VICE PRESIDENT



DR. GEORGE JOHNSON
 DELEGATE TO A. M. A.

Program Speakers

KATHLEEN AMELIA RILEY, M. D.



M. D., The Medical College of South Carolina, 1941. Residency, Dermatology and Syphilology, Duke University Hospital, Durham, North Carolina. Diplomate American Board of Dermatology and Syphilology.

Associate Professor of Dermatology, Medical College of South Carolina, Charleston, South Carolina.

J. HOWARD STOKES, M. D.

Medical College of South Carolina 1931. FACS; American Board of Ophthalmology.

Dr. Stokes likeness appears on page 166.

EDWARD F. PARKER, M. D.



Duke University, M. D. 1933. 1933-1934 Intern in Medicine, Strong Memorial Hospital, University of Rochester, Rochester, New York. 1935-1936 Assistant Resident in Surgery, University of Virginia Hospital,

University of Virginia, Charlottesville, Virginia. 1936-1939 Residency in Surgery, Vanderbilt Hospital, Nashville, Tennessee. 1942-1946 U. S. Army Medical Corps, Lt. Colonel. Clinical Professor of Surgery, Medical College of South Carolina, Charleston, South Carolina. American Association for Thoracic Surgery. American College of Surgeons. American Surgical Association. Southern Surgical Association. Diplomate American Board of Surgery. Diplomate Board of Thoracic Surgery. Consultant in Thoracic Surgery, Southeastern U. S. Veterans Administration, Atlanta Medi-

cal Area. Clinical Professor of Surgery, Medical College of South Carolina, Charleston, South Carolina—and others.

R. BRUCE LOGUE, M. D.



M. D. Emory University, 1937. Professor of Medicine, Emory University Medical School. Cardiologist Emory University Hospital. Member, Board of Directors of the American Heart Association. Past Presi-

dent and Member, Board of Directors, Georgia Heart Association. Chairman, Board of Examiners of the Sub-specialty Board in Cardiology of the American Board of Internal Medicine. Fellow, American College of Physicians. Past President, American Federation for Clinical Research. Member, American Clinical and Climatological Association. Editor, Section on Cardiovascular Disease, Annual Review of Medicine.

WILLIAM H. MULLER, JR., M. D.



M. D., Duke University, Durham, North Carolina, 1943. Internship and residency in Surgery Johns Hopkins Hospital, 1944-1949. Assistant Professor of Surgery, University of California at Los Angeles School of

Medicine, 1949-1953. Associate Professor of Surgery, University of California at Los Angeles School of Medicine, 1953-1954. U. S. Army Medical Corps, Captain, 1946 to 1947. At present, Stephen H. Watts Professor and Chairman, Department of Surgery, University

of Virginia School of Medicine, Charlottesville, Virginia.

American Association for Thoracic Surgery. American Board of Surgery, Diplomate. American Board of Thoracic Surgery, Diplomate. American College of Surgeons, Fellow. American Surgical Association. Pacific Coast Surgical Association. Southern Surgical Association—and others.

FORDE A. McIVER, M. D.

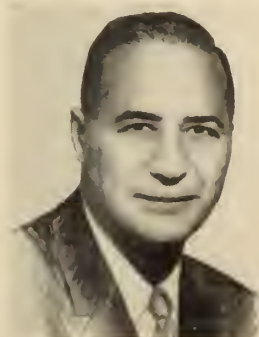


M. D. Degree 1942, Medical College of South Carolina, Charleston, South Carolina. Internship and residency 1943-1946, University Hospitals Madison, Wisconsin. Assistant Professor in Surgery (Cancer

Research) and Instructor in Pathology, 1955-1957, University of Wisconsin School of Medicine, Madison, Wisconsin. Assistant Professor in Pathology, 1957-present, Medical College of South Carolina, Charleston, South Carolina.

Certified, American Board of Surgery, 1949. Certified, American Board of Pathology, 1959.

A. R. CURRERI, M. D.



M. D., University of Wisconsin School of Medicine, 1933. Certified by the American Board of Surgery. American Board of Thoracic Surgery. Professor of Surgery and Director of the Cancer Research Hospital

and Tumor Clinic of the University Hospitals, Madison, Wisconsin.

CHARLTON deSAUSSURE, M. D.



Johns Hopkins Medical School, M. D. 1945. Internship and residency in Internal Medicine at Washington University School of Medicine, St. Louis, Missouri. Assistant Professor of Medicine at the Medical

College of South Carolina, Charleston, South Carolina.

EDGAR V. ALLEN, M. D.



M. D., University of Nebraska, 1925. Professor of Medicine, Mayo Foundation. Medical consultant for the Army, Colonel, 1942-1946. American College of Physicians. American Heart Association, President, 1956-1957. American Society for Clinical Investigation. Associate Editor of American Heart Journal from 1939-1945.—and others.

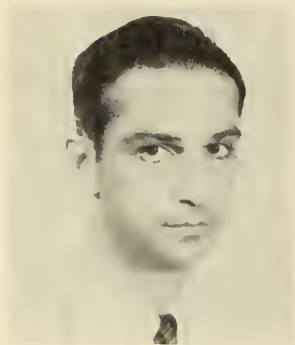
KENNETH E. APPEL, M. D.



Harvard University, Ph.D. Harvard Medical School, M. D., 1924. Professor of Psychiatry, School of Medicine, University of Pennsylvania. Director, Clinic for Functional Diseases, University of Pennsylvania Hospital.

American Psychiatric Association. Joint Commission for Mental Illness and Health. American Board of Psychiatry and Neurology—and others.

E. RANDOLPH BRADHAM, M. D.



Medical College of South Carolina, 1951. Internship and Residency at the University of Michigan Hospital 1951 to 1956. Assistant Professor of Surgery, Medical College of South Carolina, Charleston, South Carolina.

Certified, Obstetrics-Gynecology 1931. American Medical Association—and others.

GEORGE W. ANDERSON, M. D.



M. D., University of Minnesota, 1937. Internship, California Hospital, Los Angeles. Residency in Gynecology at Buffalo General Hospital, Buffalo, New York. Assistant Professor of Obstetrics, Johns Hopkins

Hospital. Assistant Professor of Pediatrics, Johns Hopkins University. Lt. Colonel Medical Corps, U. S. Army Reserve. Director of Laboratories, Providence Lying-In Hospital. Associate Professor of Obstetrics and Gynecology, Tufts University Medical School.

New England Obstetrical and Gynecological Society. American Board of Obstetrics and Gynecology—and others.

RHETT TALBERT, M. D.



M. D., Medical College of South Carolina, 1945. Internship and Residency in Medicine, Medical College of Virginia, 1945-1951. Residency in Neurology 1951-1953 and Teaching and Research Fellow in

Neurology (Neuropathology) 1953-1954, Massachusetts General Hospital. Assistant Professor of Neurology, Medical College of South Carolina, Charleston, South Carolina. Member American Academy of Neurology. Certified in Neurology by American Board of Psychiatry and Neurology.

ROBERT A. COSGROVE, M. D.



M. D., Cornell University and Residency Christ Hospital. Professor and Chairman Obstetrics and Gynecology, Seton Hall College of Medicine. Member Board of Health State of New Jersey. Major, Medical

Corps, U. S. Army.

HERBERT M. BLACK, M. D.



M. D., Medical College of South Carolina, 1937. Residency in Obstetrics-Gynecology, Louisville General Hospital, Louisville, Kentucky, 1939-1941. Commander, Medical Corps, USNR, 1941-1946.

Diplomate, American Board of Obstetrics and Gynecology, 1946.

American College of Obstetricians and Gynecologists: AMA. South Atlantic Association of Obstetricians and Gynecologists—and others.

WALTER MOORE HART, M. D.



M. D. Medical College of South Carolina, 1941. Lt. Commander, U. S. Navy. Internship at Children's Hospital, Boston, Massachusetts. Assistant Resident on Pediatrics, University of Virginia Hospital.

Certified by American Board of Pediatrics. American Academy of Pediatrics. Chairman of the Committee on Infant and Child Health of the South Carolina Medical Association—and others.

EDWARD T. KREMENTZ, M. D.



M. D. University of Rochester, Rochester, New York, 1943. Internship and residency at New Haven Hospital 1943-1950. Tulane University — Associate Professor of Surgery. Diplomate, American Board of

Surgeons, 1952. Fellow of American College of Surgeons, 1953. American Association for Advancement of Science. American Association for Cancer Research. Society of University Surgeons—and others.

HOWARD L. HOLLEY, M. D.



Medical College of S. C., 1941. Internship U. S. Marine Hospital, Norfolk, Virginia, General Rotating, 1941-1942. Residency Jefferson - Hillman Hospital, Birmingham, Alabama 1945-1947. Military Service

USPHS, U. S. Coast Guard, PAS. Reserve. Professor, Medical College of Alabama, Department of Medicine, 1959.

American Rheumatism Association. American Federation for Clinical Research. Diplomate of American Board of Internal Medicine—and others.

EXHIBITORS

W.M. POYTHRESS & CO., INC.

A cordial welcome awaits you from D. N. Patterson at the Poythress booth. Solforespine, new distinctive combination of reserpine, phenobarbital, and colloidal sulfur; Mudrane, outstanding anti-asthmatic tablet; Solfoton; and other Poythress products will be featured. We will be grateful for your requests for literature and trial supplies.

THE STUART COMPANY

The Stuart representatives extend a cordial invitation to physicians attending this meeting to visit their booth and discuss with them the latest developments of The Stuart Company. The products to be featured are MYLICON—a new product for gastric distress, and VITA-DRINK—a new pleasant-tasting multi-vitamin dosage form.

A. H. ROBINS COMPANY, INC.
Richmond, Virginia

Growing evidence in the literature attests the efficacy and safety of DIMETANE and ROBAXIN, which are featured at the Robins exhibit. Dimetane (tablets, elixir, Extentabs, Injectable) has been demonstrated as providing effective antihistaminic action with side effects no greater than a placebo. Robaxin (tablets, and the dramatically quick-acting Injectable) relaxes skeletal muscle spasm without concomitant sedation. Other Robins products shown include DONNAZYME and ALLBEE WITH C.

THE LANIER COMPANY
GRAY AUDIOGRAPH
DICTATION SYSTEMS

The Lanier Company will exhibit Gray Audiograph Dictation Systems which include the PHONAUDIOGRAPH—largest selling phone dictation system designed to meet every need of hospital records systems. Of particular interest to physicians is the "Caduceus" Model KEY-NOTER, the smallest, lightest, easiest-to-use dictating machine designed especially for the Medical Profession.

CARRTONE LABORATORIES, INC.

You are cordially invited to chat with representatives of Carrtone Laboratories, Inc., who will be pleased to supply you with information, literature and samples of their popular ethical pharmaceutical products. You will have an opportunity to learn more of DROCOGESIC NO. 3, TWIX, PRELARON, DEX-SED, PINROU, HOMVITE, and other fine pharmaceuticals.

Our representatives who will attend this meeting are:

Bob Paxton
Dave Dupre

PALMEDICO, INC.
PHARMACEUTICAL SPECIALISTS

The Palmedico exhibit will feature two new compounds which were recently released. One is Palohist—a long acting, triple antihistamine with phenyl-ephine and the other is Spasmasorb which is a combination of Adiphenine Hydrochloride and two antacids. Palmedico representatives will be present to answer any inquiries.

THE MERCK SHARP & DOHME
TECHNICAL EXHIBIT

A new adrenocortical steroid is featured at the Merck Sharp & Dohme booth. 'DECADRON' dexamethasone possesses all the basic actions and effects of other glucocorticoids but in different degree. Its anti-inflammatory activity is more potent on a weight basis than any other known glucocorticoid. Electrolyte imbalance is not ordinarily a therapeutic problem.

'HydroDIURIL', a new, orally effective, non-mercurial diuretic-antihypertensive agent is also of inter-

est. This compound is the most potent diuretic agent at present available, equaling or exceeding even the most potent parenteral organomercurials in diuretic activity.

Technically trained personnel will be present to discuss these and other subjects of clinical interest.

J. A. MAJORS COMPANY

Medical, Nursing and Dental Books of All Publishers

We welcome you to visit Booth #41 to see and examine the many new books and new editions that will be on display. New editions of such classics as—Cecil's Textbook of Medicine, Nelson's Pediatrics, Christopher's Textbook of Surgery, Conn's Current Therapy. These are now available, as well as many completely new titles like McLaughlin's Trauma and Roberts Guide to Difficult Diagnosis and others. Mr. G. E. Finch will be in charge and will look forward to seeing you then.

THE MACDONALD CO.

Will display Thermo-Fax copying products. Primarily will be demonstrating I.E.S.—Instant Electric Statements, which eliminate the month end statement bottleneck—plus giving patients a completely itemized statement, addressed and ready for mailing at the rate of 300 to 400 statements per hour. Other benefits are, SNR (Short Note Reply) for correspondence, extra copies of insurance claims, diets, etc.

SEALY OF THE CAROLINAS, INC.

We expect to show the Nationally advertised Sealy Posturepedic innerspring and foam rubber mattresses, both over their matching Posture-lok foundations, at the Annual meeting of the South Carolina Medical Association on May 17-19, 1960, at the Ocean Forest Hotel.

Posturepedic innerspring is the original of the so called "orthopedic" types of innerspring bedding. It was developed in conjunction with members of the Medical Association, and upon their advice. It is advertised in the Journal of the American Medical Association.

Posturepedic foam rubber, over its matching extra height Posture-lok foundation, closely approaches Posturepedic innerspring in firmness. It has been judged by a National Testing Company to be 50% firmer and with 75% less "Shimmy" or side sway than any other nationally advertised brand.

Both items are guaranteed for 20 years. Medical discount pricing on both items has been in effect for at least 15 years.

VANPELT & BROWN, INCORPORATED
Richmond, Virginia

VanPelt and Brown extend a cordial invitation to visit their exhibit where representatives will be happy to answer questions and supply clinical samples of their products.

WESTWOOD PHARMACEUTICALS

Westwood invites physicians to stop by their booth to discuss their unique dermatological products:

Fostex Cream, Fostex Cake, Lowila Cake, Lowila Emollient, Sebulex Alpha-Keri.

These products are particularly suitable for personal use by physicians and their families, who may be plagued with dandruff, acne, dry itchy skin and sensitivities to soap. Register, so that we may send prescription units to your home.

PET MILK COMPANY

We will be pleased to have you stop and discuss the variety of time-saving material available to busy physicians. Our representatives will be on hand to discuss the merits of "Pet" Evaporated Milk for infant feeding and INSTANT "Pet" Nonfat Dry Milk for special diets.

WARREN-TEED PRODUCTS CO.

The Warren-Teed Products Company is featuring four pharmaceutical specialties at their exhibit at Booth No. 12.

MODANE—A nutritional deconstipant for rehabilitation and relief of the atonic bowel.

ILOPAN—Injectable d-pantothenyl alcohol for the treatment and prevention of flatulent gastrointestinal distention.

ILOPAN-CHOLINE—Oral therapy for gastrointestinal gas retention in ambulatory patients.

KAON—An extremely palatable oral potassium.

Warren-Teed representatives cordially welcome all registrants to visit their display.

THE PURDUE FREDERICK COMPANY

The Purdue Frederick Company will present:

Senokot: Constipation corrective. Concentrated total senna glycosides which activate Auerbach's plexus, initiate normal neuromotility.

Arthropan: New rapidly absorbed choline salicylate, producing anti-inflammatory, analgesic, antipyretic effects in a short period of time without gastric irritation.

Pharycidin: The first triple-action throat medication. Provides medical and systemic analgesia plus antibacterial action through gargling and swallowing.

Cerumenex: Cerumenolytic for the quick removal of excessive cerumen. Contains Cerapon, a new surfactant, with propylene glycol and chlorbutanol.

BORDEN

Most important new item at the Borden Pharmaceutical Division's booth is **LIQUID BREMIL** which adds all the convenience of a liquid to the significant advantages already established by **BREMIL**. Powdered Borden's full line of formula products is on display including **MULL-SOY**, the original hypoallergenic formula. Other new additions are **DERMA-BASE** and **JUNITAR**, the nonstaining tar bath, and

MARCELLE Hypoallergenic Cosmetics, pure beauty aids for delicate skins.

THE S. E. MASSENGILL COMPANY

Best wishes from Massengill to the South Carolina Medical Association for a most successful meeting. Should you desire, Massengill service representatives will be on hand at the Massengill booth to discuss with you any Massengill product in which you are interested. The S. E. Massengill Company and its service representatives would like to cooperate, in any way possible, to make your meeting a complete success.

WINCHESTER SURGICAL SUPPLY COMPANY

"Carolinas' House of Service"

119 East 7th St., Charlotte, N. C.

We invite you to visit our booth #36 where we will have on display the latest in Medical and Surgical Equipment and Supplies. Emory Floyd, Tom Coble and R. M. Conder will be there to greet you.

WESTINGHOUSE ELECTRIC CORPORATION

X-Ray Division

Westinghouse is looking forward to showing you top line equipment and discussing your x-ray problems.

ABBOTT LABORATORIES

Of particular interest to physicians at the Abbott booth will be the presentation of **Desoxyn** Gradumets—the new long-acting dosage form now being used in obesity cases. Abbott will also display antibiotics, hospital solutions and equipment. Our representatives will be on hand to assist you in every way possible.

CHARLES C. HASKELL & COMPANY

Featuring **ISOCOLOR**, a new antihistamine-decongestant for oral relief of nasal, sinus, and chest congestion. **ISOCOLOR** extends the range in decongestant therapy from relief of simple nasal congestion only, to include chest discomfort; to permit free breathing and inhibit excessive mucosal discharge, post-nasal drip, and resulting night cough.

The Haskell representative will be happy to discuss new developments in connection with the familiar **Belbarb**, **Hasamal**, **Hasacode** products.

WARNER-CHILCOTT LABORATORIES

Nardil—Safe, new, rapidly effective treatment for true (endogenous) depression, restores depressed and despondent patients to reality with no toxic effect on blood, liver or kidneys.

Gelusil—the physician's antacid—for the relief of gastric hyperacidity and management of peptic ulcer. Clinically superior because it is nonconstipating. Ideally suited for the peptic ulcer patient because it contains no laxative which might cause irritation and hypermotility.



THE WM. S. MERRELL COMPANY

You are cordially invited to visit booth number 1 where The Wm. S. Merrell Company has on display products of particular interest to the doctor.

Cooperative and highly trained Merrell representatives will be on hand to answer your questions. These men will be most happy if you plan to spend some time with them.

We look forward to visiting with you during this fine convention.

SANDOZ PHARMACEUTICALS

Sandoz Pharmaceuticals cordially invites you to visit our display at booth #22.

MELLARIL—the first potent tranquilizer with a selective action (i. e.—no action on vomiting centers). This unique action gives specific psychic relaxation with safety at all dosage levels.

PLEXONAL—preferred daytime sedative—relaxant. Superior to both the barbiturates and Meprohamates.

CAFERGOT PB—the most effective oral medication for the relief of migraine headache with G. I. disturbance accompanied by tension.

Any of our representatives in attendance, will gladly answer questions about these and other Sandoz products.

<i>Exhibitors</i>	<i>Booth Number</i>
Abbott Laboratories	35
A. S. Aloe Co. of Ga.	43
The Borden Company	40
The Carnation Company	16
Carrione Laboratories	11
Ciba Pharmaceutical Products, Inc.	33
Doho Chemical Corporation	10
Edison Voicewriter Company	25
Eli Lilly & Co.	8
Geigy Pharmaceuticals	29
Charles C. Haskell & Co.	15

G. D. SEARLE & CO.

Chicago, Illinois

You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle Products of Research.

Featured will be our new Aldosterone-Blocking Agent for edema or ascites, Aldactone.

The Lanier Company	5
Lederle Laboratories	37
The MacDonald Company	26
J. A. Majors Company	41
The S. E. Massengill Co.	23
Mayrand, Inc.	27
Mead Johnson & Co.	13
Medco Products Co., Inc.	20
Merk, Sharp & Dohme	28
The William S. Merrell Co.	1
Palmedico	38
Parke, Davis & Co.	14
Pet Milk Co.	30
Powers & Anderson	9
Wm. P. Poythress & Co.	39
The Purdue Frederick Co.	21
A. H. Robins Co., Inc.	44
Roche Laboratories	3
J. B. Roerig & Co.	32
Sandoz Pharmaceuticals	22
Sealy of The Carolinas	2
G. D. Searle & Co.	19
Smith, Kline & French Laboratories	24
The Stuart Company	6
Van Pelt & Brown, Inc.	34
Wachtel's Physician Supply Co.	42
Warner-Chilecott Laboratories	31
Warren-Teed Products Company	12
Westinghouse X-Ray Division	4
Westwood Pharmaceuticals	7
Winchester Surgical Supply Company	36

ELI LILLY AND COMPANY

You are cordially invited to visit the Lilly exhibit located in space No. 8. The Lilly sales people in attendance welcome your questions about Lilly products and recent therapeutic developments.

The following Lilly salesmen will be in attendance at our exhibit during the meeting.

Mr. D. M. Burns (in charge of exhibit)

Mr. W. W. Howle

J. B. ROERIG AND COMPANY

J. B. Roerig and Company will welcome members of the medical profession at the company's exhibit of leading specialties and new products. Representatives will be in attendance to answer any questions you may have. Roerig recently introduced a number of new products which representatives at the exhibit will describe and give information on the results of clinical reports.

CARNATION COMPANY

Carnation Company cordially invites you to visit our Booth, where Medical Specialist representatives will be pleased to welcome old and new friends of the South Carolina Medical Association.

Recent literature and information regarding Carnation Evaporated, Carnation Instant Non-Fat, and our newest product CARNALAC are available.

Any question pertaining to our physician-researched material for use in your practice or hospital will be cheerfully discussed.

SMITH, KLINE, AND FRENCH

S.K.F. features: (1) new 'Ornade' Spansule capsules, the unique oral nasal decongestant that contains a special drying agent in addition to a decongestant and an antihistamine; (2) 'Fortespan' capsules, high potency multivitamins (therapeutic formula) in Spansule sustained release capsules; and (3) 'Eskatrol' Spansule capsules, the tranquilizer-anorexic to relieve underlying psychic stress and curb appetite in psychogenic overweight.

GEIGY TECHNICAL EXHIBIT

GEIGY PHARMACEUTICALS cordially invites Members and Guests of the Association to visit its technical display. Tofranil, a new agent, specifically for depression, will be featured. Information on other products valuable in the therapy of rheumatic, metabolic, dermatologic and cardio-vascular diseases will be presented by personnel in attendance.

MEAD JOHNSON & COMPANY

The Mead Johnson exhibit has been arranged to give you the optimum in quick service and product information. To make your visit productive, specially trained representatives will be on duty to tell you about their products.

PARKE, DAVIS & COMPANY

Medical service members of our staff will be in attendance at our booth to discuss important Parke, Davis specialties which will be on display.

Committee Reports 1959-1960

COMMITTEE ON CANCER

Two thousand nine hundred and twenty-five new cases of cancer were reported to the Section of Cancer Control during the year. One thousand three hundred and sixty (386 white males, 446 white females, 180 Negro males and 348 Negro females) new cancer cases were reported by the eleven State-Aid Cancer Clinics, and 1,565 (608 white males, 801 white females, 65 Negro males and 91 Negro females) new cancer cases were reported by private physicians.

Of the new cases reported there were approximately 3.3 white cases for each colored case. As was to be expected, more females than males were reported as having cancer, the rate being 1.33 to 1. The majority of new cases of cancer in Negroes were reported by the cancer clinics. Negroes comprised only 10% of the total cancer cases reported by private physicians.

An additional 3,004 old cancer clinic patients were examined periodically by the State-Aid Cancer Clinics in order that any recurrence of the disease might receive prompt attention. A grand total of 5,929 cancer patients received treatment and follow-up ser-

vices by the State-Aid Cancer Clinics and private physicians.

Our Committee would like to call to your attention the fact that of the 2,373 patients referred to the Cancer Clinics by you, 1,013 or 43% proved to be free of cancer after complete examinations. Since the Cancer Clinics are for the treatment and follow-up of indigent cancer patients, it is respectfully requested that you have a reasonable high suspicion of the patient having cancer before you refer him or her to the Clinics.

Dr. James R. Young,
Chairman

Dr. H. R. Pratt-Thomas
Dr. Alton C. Brown
Dr. Percy D. Hay, Jr.

Dr. Leland J. Brammon
Dr. Edward S. Cardwell
Dr. Thomas A. Pitts

COMMITTEE ON LIAISON WITH ALLIED PROFESSIONS

This Committee has had no problems or questions referred to it and has not initiated any activity of its own. This report therefore is a completely negative one. Nevertheless, because of the many possible prob-

lems, mutual to the professions, which may arise from time to time, I think that the Association should continue to include this Committee in its Standing Committees.

Most of the previous thought in connection with this Committee has been in relation to the profession of law, and in particular in relation to the question of suits for malpractice. This is an important problem and one in which our association and advice from the members of the bar have stood us in good standing in the past. However, we should also bear in mind that it is important to maintain contact with, and mutual respect for, our friends of the professions of pharmacy, dentistry, and veterinary medicine. Our friends of the pharmaceutical industry have recently been the target of an "investigation" which in my opinion should be placed in the category of a witch hunt. There are those politicians who are constantly searching for similar targets and should the medical profession be next in line we will need the support of our friends.

With these rather scattered thoughts I pass on the torch to the next Chairman.

Henry C. Robertson, Jr., Chairman

AMERICAN MEDICAL EDUCATION FOUNDATION COMMITTEE

Edwin Boyle, Jr., M. D.

R. L. Crawford, M. D. Keitt Smith, M. D.

Henry L. Laffitte, M. D. Herbert A. Gross, M. D.

The conclusion of the 1959 year found a marked increase in funds contributed by physicians to medical education through the foundation. The foundation closed its 1959 books on January 31, 1960, with a national total of \$1,195,824.79, an increase of \$75,780.10 over the 1958 total. The 1958 total also included a gift from the American Medical Association of \$100,000. The total increase in contributed money is therefore \$175,780.10, or a 17.2% increase over the amount contributed in 1958. This increase, as compared to 1957, shows an extraordinary 36.7%.

South Carolina is proud and pleased to report that its total for 1959 was \$68,634.44. This is a substantial increase over the amount donated in 1958, which was \$40,149.36. Only two other states in the nation contributed more than South Carolina, and they are California and Illinois. This makes South Carolina number three in the nation for donations.

However, coupled with this good news of substantial increase is the distressing fact that the number of contributors in South Carolina decreased from 744 in 1958 to 223 contributors in 1959. This means that less than one-third as many contributors have donated over one and one half times as much money.

As probably known, every cent contributed goes directly to the medical schools that they are earmarked for. All expenses, administrative and otherwise, are paid through the generosity of the American Medical Association. The above stated figures indicate two important facts. (1) The appearance of a grossly decreasing number of physicians participating by

contributions, which is alarming. (2) It shows also that a smaller number of people are contributing much larger amounts and carrying much more than their share. This apparently means that the larger part of the contributions from South Carolina came from the members of the full-time faculty of the Medical College through its self-imposed program of turning back to the institution through the American Medical Education Foundation any excess professional income beyond a uniform limit established by themselves. Dr. Kenneth M. Lynch, President of the Medical College, states that without American Medical Education Foundation contributions and associated National Foundation for Medical Education support, clinical and basic science departments would be short of badly needed funds not provided by state appropriations to augment their teaching programs. Upon this demonstration of interest in medical education through American Medical Education Foundation contributions depends the participating support, in like or larger amounts, by industry through its own organization, the National Foundation for Medical Education. As all funds given are to help support the medical schools designated are not to replace items in their regular fiscal budget, but to augment salaries of teaching personnel, teaching programs, or for building expansion. It is felt with reasonable sureness that South Carolina will again rate at the top of the nation in individual contributions and total per capita contributions percentage-wise. It is hoped that through the American Medical Education Foundation a continued expansion program to provide better trained doctors for our state in the future will continue to prosper. An addendum to this report will be submitted when honor roll contributors for South Carolina becomes available.

Respectfully submitted,

Edwin Boyle, Jr., M. D., Chairman

ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

The affairs of the Woman's Auxiliary have been efficiently conducted by the President, Mrs. Ramsbottom, and the other officers during the past year. There have been no calls on our committee for advice or counsel. We would like to congratulate Mrs. Ramsbottom on her capable handling of the business of the organization and the success of the Auxiliary's major activity for 1959.

R. L. Crawford, M. D., Chairman

THE COMMITTEE ON PUBLIC HEALTH

The Committee on Public Health of the South Carolina Medical Association consists of the following:

Douglas Jennings ----- Bennettsville
Wallace D. McNair ----- Aiken
Casper Wiggins ----- Greenwood
W. Wyman King ----- Batesburg

This committee has attempted to function via telephone, mail and had one called meeting in Columbia.

Early in the year the committee offered its services to the South Carolina State Board of Health, with the feeling that it could best function in that manner. However, we were not called upon for any service, but since the Chairman is a member of the Executive Committee of the S. C. State Board of Health, it is felt that the committee, at least indirectly had a voice in all public health activities in the State.

The Committee feels that, in as much as the majority of the Members of the Executive Committee must, by law, be Members of the S. C. Medical Association; the Association actually controls health activities in the State and the Committee on Public Health is superfluous and actually has no function. We, therefore, recommend that it be completely abolished or inactivated until such time as an emergency arises which would probably make it useful.

Respectfully submitted,
W. Wyman King, Chairman

REPORT OF COMMITTEE ON CERTIFICATION OF PSYCHOLOGISTS

The South Carolina Medical Association Committee on Certification of Psychologists during the year held informal discussions with physicians and interested persons over the state.

During the session of the General Assembly, and up to the time of this report, the committee members were fearful and alert for new legislation which might be concerned with the work of the Committee.

Certification of Psychologists were studied at the Joint Committee Meeting of the American Psychiatric Association and the American Psychological Association in May 1959. Psychiatrists are deeply concerned for the medical protection of individuals treated by psychologists. They are in disagreement with the Psychological Association over the legal difference between "Certification Legislation and Licensing Legislation" for psychologists. Certification would mean to set up standards for their own group. They desire licensing to be able to practice counseling and psychotherapy on emotionally ill patients.

Council of the American Psychiatric Association encourages the Committee to work closely with "The American Medical Association, nationally and at state levels, to try to defeat certification bills that do not clearly state that medical responsibility lies with the physician, and/or do not include the Code of Ethics of the American Psychological Association, which requires close collaboration with a physician, preferably a psychiatrist under penalty for violation".

We are warned on a national level that physicians can expect mounting pressure from psychologists to treat their patients in general hospitals.

The S. C. Medical Association must be mindful of this problem and carefully examine any new legislation in this area. This is mandatory, so that the diagnosis and treatment of nervous and mental illnesses,

like other illnesses, shall remain a medical responsibility.

F. C. Owens, M. D. James B. Galloway, M. D.
John M. Brewer, M. D.
Joe E. Freed, M. D., Chairman

COMMITTEE ON WELFARE AND REHABILITATION

The annual meeting of the committee was held on March 6, 1960, in Columbia, South Carolina, with the following members present: Dr. John A. Siegling, Charleston; Dr. Harry W. Mims, Charleston; and Dr. Ben N. Miller, Chairman, Columbia. Dr. Roderick Macdonald, Rock Hill, and Dr. John K. Webb, Greenville, were absent because of conflicting engagements.

The problem of collection of funds from the public for medical purposes was included in the report of this committee in 1959, and at that time it was recommended that this be investigated on a local level and be brought back for further consideration. Study indicates that in the recognized fields of medical solicitation the system of collections and the handling of funds is on a sound business basis. These funds are used in a wise and an advantageous way for the promotion of research and medical education. It is hoped that in the future these campaigns can be combined under some system advantageous to the agencies concerned; however, no definite recommendation is made by your committee at this time. The control of unproved agencies must necessarily come under state and municipal regulatory laws, and the medical profession can act only in an advisory capacity to the various agencies concerned.

Due cognizance was taken of the agencies in the field of rehabilitation and welfare.

Vocational Rehabilitation in our state has done an admirable job during the past year. The agency is supported by a medical advisory committee; and through the advice of this medical group, the fee schedule has been brought up to date. It is recommended that a close liaison be maintained by the Welfare and Rehabilitation Committee of the South Carolina Medical Association with the medical advisory group to Vocational Rehabilitation.

The Department of Public Welfare is an integral part of the overall care of the indigent, medically and otherwise. At a local level much is to be gained by close cooperation of the profession with the agency.

Blue Cross - Blue Shield has enlarged its activities to include the older age group of our population. This is provided for by a special premium and fee schedule. This has the endorsement of the committee.

Pending legislation on the national level proposing the extension of medical care to welfare and social security recipients will further seriously tax the national economy. This legislation is contrary to the judgment of the committee.

The problem of matching federal funds with state appropriations for rehabilitation and welfare was again considered. As in the former report, it was felt

that where proof of need for funds is shown and where facilities for administering these funds properly prevail appropriations of state funds in order to secure federal matching funds should be encouraged. Some moderation in judgment is solicited for the protection of the taxpayers and the budget in general.

Respectively submitted,

Ben N. Miller, M. D., Chairman
 John A. Siegling, M. D. Roderick Macdonald,
 Harry W. Mims, M. D. M. D.
 John K. Webb, M. D.

COMMITTEE ON LEGISLATION AND PUBLIC RELATIONS

As the Legislature is in mid-season the report made at this time is as the situation is today and subject to change during the Legislature session. Your Committee has studied the various bills which are interesting to the medical profession and conferred with the President of the Medical Association, the Executive Secretary and various other officials of the Association and have obtained the cooperation of doctors over the State in imparting information to certain members of the Legislature. We want to thank the officials and members of the profession for their cooperation.

There has been introduced this year a bill by the osteopaths which would allow them to virtually practice medicine as freely as do the medical doctors in the State, although there are only six or seven osteopaths practicing in South Carolina under the present osteopathic law. If this law was changed as they desire it to be we are inclined to believe it would influx osteopaths from over the country to South Carolina.

The crux of the bill is as follows: "The holder of a license granted by the board shall be subject to the same duties and obligations and authorized to use the same diagnostic and therapeutic agencies and modalities, without exception, in the practice of his profession utilized by physicians and surgeons of other complete schools of medicine and surgery, including the use of drugs and operative surgery with instruments." Some of the osteopaths colleges have a very complete curriculum but it is felt by many that some of the osteopaths have not had sufficient training to be allowed the full right of practice of medicine on people of South Carolina. This bill is at present in Committee.

There has again been introduced a bill to require the separation and labeling of blood in blood banks, white and colored. We have had doctors over the State furnish information to members of the Legislature to the effect that neither chemical nor microscopic tests can determine the difference in white or colored blood and that within four months after a transfusion is given there has been not only no reproduction by these cells but every transfused cell has been destroyed in the system. The passage of this act will greatly hinder the giving of blood by blood banks when it is needed. This bill is in Committee.

Chiropodists came up with another bill and originally deleted several sentences from the bill which deletion would make the bill unacceptable to the medical profession. Conferences between representatives of the chiropodists and Mr. Meadors has resulted in the putting back of the deleted sentences so that the bill is now apparently innocuous.

There is introduced another bill related to naturopathy. The prime mover is Representative Mitchell who himself is a naturopath. This bill is still unacceptable; however, it must be realized that Representative Mitchell has created a great deal of sympathy among certain members of the Legislature. We believe, however, that these members will see the bill in its true lights if and when it comes out of the Committee.

For the Committee:

Frank C. Owens, Chairman
 Bachman S. Smith, Jr., Harold E. Jervey, M. D.
 M. D. Joseph I. Converse, M. D.
 James H. Gressett, M. D. Alton G. Brown, M. D.
 C. Tucker Weston, M. D. George H. Orvin, M. D.
 James C. McAlpine,
 M. D.

MATERNAL WELFARE COMMITTEE

The Maternal Welfare Committee of the South Carolina Medical Association held its first meeting in the conference room of the State Board of Health, Columbia, in August of 1959. Since that time two subsequent meetings have been held with excellent attendance. An encouraging note has been the presence of physicians at the meetings who are not a member of the Committee but interested in the maternal health on a statewide basis.

All maternal deaths through December of 1957 have been reviewed and an accurate compilation made. At the present time, the Committee is in the process of completing a review of the deaths for 1958 and 1959.

As a rule, the cooperation of the physician in attendance at the time the maternal mortality occurs has been very good, however, on occasion the process of having him forward the information to the Committee requires unnecessary time and effort. It is therefore urged that a request for early and accurate reporting of maternal deaths be presented at the state meeting and all physicians asked to cooperate as soon as possible following a maternal death.

The following is a classification based on the primary causes of maternal deaths during the year 1957.

CAUSES OF MATERNAL DEATHS IN 1957

Uterine hemorrhage	18
Toxemia	15
(Eclampsia) (13)	
Infections	8
Cardiac failure	7
Ruptured ectopic pregnancy	6

Pulmonary embolism	5
Cerebral hemorrhage	5
Chronic pyelonephritis	1
Anesthesia	1
Anemia, chronic	1

Respectfully submitted,

E. J. Dennis, M. D. Chairman

COMMITTEE ON HISTORICAL MEDICINE

This Committee has continued to collect and organize material for a history of medicine in South Carolina. The chairman has obtained some financial assistance from the National Institutes of Health toward research and compilation. The committee would like to ask for one more allotment of \$500.00 to be added to our present funds for eventual publication.

J. I. Waring, Chairman

Chapman Milling, M. D. R. Eugene Zemp, M. D.
R. M. Pollitzer, M. D. William A. Boyd, M. D.

MEDICAL CIVIL DEFENSE

There was an entirely new set-up of Civil Defense including the medical branch of Civil Defense that was drawn up by Gen. Wm. L. Cork and a staff and completed about May, 1959. Immediately after my induction into the office as president of the South Carolina Medical Association, I was informed by Gen. Cork and his group that I would be head of the Medical Civil Defense as the president of the State Medical Association.

This document was beautifully done. The maps which they have prepared, I intend to bring to Myrtle Beach so as to have them on display. The chiefs of the various departments were selected in this area. The directors who have headed the groups of the Civil Defense directed that each of these heads shall be in Columbia where the headquarters of the South Carolina Civil Defense is located.

The state is divided into six districts according to the congressional districts of South Carolina. Each district has its doctor as chief and each one of these department heads appoints his county medical staff so that each county has its Medical Civil Defense Chief and a similar alignment.

There have been several meetings with Col. Charles F. Colyer and Col. Robinson of the Civil Defense Headquarters. The medical staff met with the director of the State Civil Defense in Columbia, September 18, 1959, with Mr. Charles B. Culbertson and his staff. Dr. William McAnnally, Jr. was the moderator.

November 17, 1959, I attended a statewide Civil Defense meeting at the Jefferson Hotel.

Dr. Charles R. May of Bennettsville attended the meeting of doctors in Civil Defense for the atomic fallout which was held at Brooke Army Medical Center, Fort Sam Houston, San Antonio, Texas, February 15-19th, 1960. I will request that some report be included from him.

Last week I had an urgent message requesting a representative from the Medical Association to attend

a meeting on the 2, 3, and 4, of March in Atlanta. This was for the Southeast District of Civil Defense. I tried in vain to get one of our doctors, especially one of the chiefs, to attend but did not succeed. I telephoned Dr. Charles N. Wyatt of Greenville who was successful in getting Dr. Eugene Yeargin to attend. I am enclosing a list of the doctors who have been appointed as chiefs throughout the state and locally also.

The Civil Defense Newsletter which has been published by the director, Mr. Charles B. Culbertson, I find very worthwhile reading.

There is only one mobile unit set-up in South Carolina and that is at the Greenville General Hospital, Greenville. There has been one authorized March 4, 1960, to be set up in Columbia, at Columbia Hospital. My chief regret in regards to Civil Defense is that there have been no shelter units provided for, and I recommend that the United States Government spend some money for this purpose so as to have sufficient shelter areas throughout the United States including this state.

Respectfully submitted,

William Weston, Jr., M. D.

ADVISORY COUNCIL ON CIVIL DEFENSE SOUTH CAROLINA MEDICAL ASSOCIATION

Chief #1

Asst. Chief #2—Dr. Manly E. Hutchinson, 1427 Gregg Street, Columbia, S. C.

Asst. Chief #3—Dr. Charles N. Wyatt, 301 E. Coffee Street, Greenville, S. C.

#3

Branch Chiefs—Dr. Frank C. Owens, 1319 Laurel Street, Columbia, S. C.

#4—Dr. O. B. Mayer, 1220 Pickens Street, Columbia, S. C.

#5—Mr. J. M. Daniel, Supt., Columbia Hospital, Columbia, S. C.

#6—Mr. E. P. Barnes, Columbia Hospital, Columbia, S. C.

#7—Mrs. J. M. Davis, 846 Arbutus Drive, Columbia, S. C.

#8—Dr. Hugh H. DuBose, 1840 Hampton Street, Columbia, S. C.

#9—Dr. George H. Bunch, 1400 Barnwell Street, Columbia, S. C.

#10—Dr. Walter W. Theus, 1513 Gregg Street, Columbia, S. C.

#11—Dr. E. DuBose Dent, Jr., S. C. Baptist Hospital, Columbia, S. C.

#12—Dr. Charles R. Holmes, 1840 Hampton Street, Columbia, S. C.

#13—Dr. George W. Brunson, 1406 Gregg Street, Columbia, S. C.

#14—Dr. John Campbell, 3800 Devine Street, Columbia, S. C.

#15—Dr. W. Campbell McLein, 1404 Gregg Street, Columbia, S. C.

#16—Dr. James F. Williamson, 1433 Gregg Street, Columbia, S. C.

#17—Dr. E. C. Kinder, 1804 Hampton Street, Columbia, S. C.

Area Chiefs.

A.—Dr. I. Grier Linton, 154 Wentworth Street, Charleston, S. C.

B.—Dr. William S. Hall, State Hospital, Columbia, S. C.

C.—Dr. Casper B. Wiggins, E. Medical Arts Building, Greenwood, S. C.

D.—Asst. Chief. 1. Dr. Charles N. Wyatt, 301 E. Coffee Street, Greenville, S. C.

2. Dr. William C. Herbert, Jr., 109 Catawba Street, Spartanburg, S. C.

E.—Dr. Sam G. Lowe, 237 S. Charlotte Avenue, Rock Hill, S. C.

F.—Appointed—Dr. Charles R. May, 210 Market Street, Bennettsville, S. C.

THE EXECUTIVE COMMITTEE OF THE SOUTH CAROLINA STATE BOARD OF HEALTH

New approaches to meet new conditions affecting the health of South Carolinians might well characterize the major portion of the activities of the Executive Committee of the South Carolina State Board of Health during 1959-1960. Particular consideration has been given public health problems of the aging and chronically ill; the control of radiation hazards; amendments to the Hill-Burton Act; American Medical Association recommendations on administering of poliomyelitis vaccine; air pollution control; water, drainage, and waste disposal for newly developed subdivisions; mental retardation; importation of shellfish; viral diseases; and accidental deaths and injuries. Matters related to the well-established activities of the State Board of Health have been carefully studied and when necessary appropriate action has been taken to maintain these services at the highest level of efficiency.

At the May 13, 1959 meeting of the Executive Committee Dr. W. R. Wallace was reelected Chairman of the Committee; Dr. Frank C. Owens was reelected Vice-Chairman; and Dr. Frank Owens and Dr. V. F. Platt were reelected to serve on the Water Pollution Control Authority Board.

Surveillance of the common bacterial and viral diseases has been maintained and through investigation and cooperation with local health departments and physicians attempts have been made to confirm by laboratory methods as many cases as possible. The majority of the former prevalent bacterial diseases remained under control during 1959 with only 31 cases of diphtheria, 13 cases of sporadic typhoid fever, one case of malaria in a member of the Air Force, and 88 cases of poliomyelitis being reported. Of the 88 cases of poliomyelitis, 68 occurred in white and 20 in the Negro populations, and 59 were paralytic. Forty-six were in the age group 0-4 years and 25 in the 5-9 year olds. Forty-six of the cases had received no vaccine, five paralytic cases had had three or more regularly spaced doses. Type I poliomyelitis virus was

isolated from 23 of the 88 reported cases, including the five triply vaccinated paralytic cases, and Type III from one non-paralytic case who had had one dose of vaccine.

In regard to the poliomyelitis inoculation program, the Executive Committee has adopted the program recommended by the American Medical Association. The Committee has also adopted the recommendation of administering four doses of Salk poliomyelitis vaccine. At the present time there are several bills before the South Carolina General Assembly requiring compulsory vaccination of school children against diphtheria, whooping cough, tetanus, and poliomyelitis. The Executive Committee passed a resolution that the bills now before the Legislature be held over pending a study and recommendations from the South Carolina Medical Association.

Influenza began to occur in the fall of 1959, and reached moderate epidemic proportions in localized areas in most counties in the State. It was not a widespread outbreak such as occurred in 1957. Types A and Asian Influenza were confirmed by laboratory examinations. Investigation has revealed that there have been some small outbreaks of aseptic meningitis due to ECHO and Coxsackie viruses. A few small outbreaks have occurred in which no etiological agent could be determined and they appear to be epidemic neuromyasthenia.

Emphasis is being shifted to the public health aspects of chronic diseases. Attention is being given first to improvement of nursing care in nursing homes by visits of public health nurses and the teaching of classes for aides in nursing homes. Almost all county health departments are participating in this program, but four counties are conducting specialized demonstrations to determine what role the county health department can have in this expanding problem of chronic diseases.

The Insect and Rodent Control Program continued with 43 of the 46 counties participating in the control of disease carrying insects. This program consisted of aerial sprays, fogs, mists, and residual sprays. Aerial spray, utilizing 6,600 pounds of dust, following Hurricane Gracie was of great benefit to the people of Beaufort, Jasper, Hampton, Charleston and Colleton counties. The landfill method of garbage disposal is being expanded annually to more cities and towns, and is of permanent effect in controlling flies and rodents. Easley has recently set up a sanitary landfill to become the thirty-seventh South Carolina town utilizing this plan.

The Rabies Control Program during the past nine years has resulted in reducing rabies almost to a minimum. Only 21 positive animal heads were diagnosed in the State Board of Health Laboratory in 1959, as compared to 350 in 1951, with approximately the same number of total heads being examined. Human treatments declined from 2973 in 1951 to only 540 in 1959. During 1959, in the annual dog vaccination program, there were 58,273 dogs vaccinated against rabies.

Of the 2236 known active cases of tuberculosis, 51.3% are not hospitalized. One hundred and nine of the 1,148 persons at home with known active tuberculosis have positive sputum and are a constant source of danger to their associates. It is axiomatic that the proper supervision of active cases of tuberculosis at home cannot be carried out unless the sputum status is known. Of the total number of patients hospitalized, 232 left the sanatoria or hospitals without permission during the year. White males led with 116; Negro male, 59; white females, 33; and Negro females, 24. Since the advent of chemotherapy as the major measure in the treatment of tuberculosis it has increasingly become the responsibility of the county health departments and private physicians to supervise patients at home on drug therapy prescribed by the sanatoria after they are discharged. Figures from the Central Register reveal that approximately 750 of these patients are on chemotherapy at home under the supervision of the county health departments and/or private physicians.

During the year more emphasis has been placed on the tuberculin testing of infants and pre-school children. All tuberculin positive infants and children up to three years are given INH as a prophylactic measure. It has been shown that by this procedure 75% of the complications of tuberculous infection can be prevented. All X-ray units contain safeguards against radiation dangers, and are under surveillance. By following these precautions, a program to take X-ray films on all individuals with pulmonary signs or symptoms has continued.

With the allocation of additional Federal funds from the Children's Bureau a new cooperative program between the Crippled Children's Division, the Section of Heart Disease Control, and the Heart Clinic at the Medical College for the care of children under 21 years of age with congenital heart disease has been put into effect. These patients are seen at the Medical College Heart Clinic and the necessary heart surgery is provided in Charleston.

Tuition and travel expenses were paid for four physicians interested in heart disease control activities to attend a Seminar on Congenital Heart Disease at Emory in Atlanta, Georgia. A series of tape recordings of heart murmurs and heart irregularities has been presented to the medical staffs of four hospitals.

During the year 2,925 new cases of cancer were reported to the Section of Cancer Control. One thousand three hundred and sixty new cancer cases were reported by the eleven State-Aid Cancer Clinics, and 1565 new cancer cases were reported by private physicians. Of the new cancer cases reported there were approximately 33 white cases for each case in Negroes. As was to be expected, more females than males were reported as having cancer, the rate being 1.33 to 1. Cancer nursing and follow-up services have been strengthened in the State-Aid Cancer Clinics at Florence and Greenville by the addition of a nurse at each clinic.

The VD Morbidity Report for the calendar year 1959 as shown below represents a 27% increase in total venereal disease over the previous calendar year:

Syphilis	Total	White	Colored
Prim. & sec.	255	36	219
Early latent	675	93	582
Late and L. latent	2,954	472	2,482
Congenital	314	31	283
	<u>4,198</u>	<u>632</u>	<u>3,566</u>
Gonorrhea	10,177	2,075	8,102
Chancroid	31	10	21
Granuloma Inguinale	9		9
Lymph. Gran. Venereum	3		3
Total Venereal Disease	<u>14,418</u>	<u>2,717</u>	<u>11,701</u>
VD Rates:			
(per 100,000 population)	Total Syphilis	Early Syph. (Prim. & Sec)	Gonorrhea
Continental U. S.	69.3	14.9	137.0
South Carolina	195.5	43.3	334.9

In each of the above rates South Carolina ranks *fourth* highest among all states in VD morbidity. Approximately 85% is among the Negro race.

Private physicians are now reporting 50% of all VD cases, as result of a new reporting system for syphilis developed in 1955 and a new system for gonorrhea reporting developed in January, 1959. Teenagers (13-16) constitute 33% of all VD reported in South Carolina. Patients under 25 years of age account for 67% of gonorrhea and infectious syphilis.

A plan has been activated with the State Board of Education for a long-range educational program, starting at top level (State Board of Education); then through the colored High School Administrators, State College faculty at Orangeburg, 4-H Club district groups, and others. Radio and TV programs have been broadcast from South Carolina Stations and the usual other channels of communication have been utilized.

Epidemics of early syphilis still are occurring in many sections of the state, from Greenville to Myrtle Beach, involving many hundreds of people. This emphasizes the importance of reporting of early cases (Prim. & Sec.), not only by county Health Departments but by the private physicians as well, so that these patients may be interviewed for contacts in order that other infected persons in the chains may be found and brought to treatment.

In 1959 (fiscal) 43,800 serologic tests for syphilis were made during selective and cluster-testing surveys, giving an overall reactor rate of 6.2 per cent.

A program was instituted in 1959 to encourage hospitals in this State to do routine blood-testing on all out-patient and staff cases. This program began with the cooperation of the Medical College Hospital, wherein during the first six weeks 2,695 patients were tested, giving a reactor rate of 13.6 per cent. This

program has subsequently been extended to include eighteen hospitals now participating in the plan. To date over 7,000 tests have been made as a result.

As the result of an incident culminating in the blood testing of the crew of a cruise ship docking in Charleston, and which yielded 27% positives, a program was instituted for blood testing of crews of merchant ships and others plying the coastal waters of this country. This has been done in cooperation with Customs and Quarantine authorities in Charleston (and shipping companies) and the Health Departments of other states bordering on the Atlantic and Pacific Oceans, the Gulf of Mexico and the St. Lawrence Seaway.

The Executive Committee approved a one-day Seminar on the Control of Venereal Diseases which was sponsored by the South Carolina Medical Association, the Columbia Medical Society, and the South Carolina Chapter of the American Academy of General Practice. This Seminar conducted in Columbia in April, 1959, was instituted primarily for the benefit of private physicians and was approved for five hours post-graduate credit by the American Academy of General Practice. The faculty consisted for the most part of out-of-state speakers who have been recognized as leading authorities on the subject in this country.

On February 10, 1960, the Executive Committee approved a proposal by Dr. R. W. Ball, Chief of the VD Control Section, for a study to be made as an evaluation of the efficacy of Declomycin in the treatment of syphilis. This broad-spectrum antibiotic is prepared and distributed by Lederle Laboratories and, while it has proven to be superior in many ways to some of the other tetracyclines, they have no data available concerning its use in the treatment of syphilis. Lederle has agreed to furnish all of the antibiotics and other materials needed for the study, which is expected to begin in the near future.

Feeling the need for clarification of certain factors involved in connection with the VDRL, an article on the subject was written and published in the March, 1960, issue of the *Recorder*, of the Columbia Medical Society. This article deletes technical detail as far as possible, and gives a laboratory and clinical interpretation of results, with special consideration being given to the everyday problems of the private physician.

A collection of various policies and procedures relating to VD Control has been compiled by the VD Control Section in the form of a Kit or Brochure for the information of private physicians, especially those who have only recently entered private practice. It contains information on the various VD services available to the practicing physician, together with VD treatment schedules, diagnostic criteria, epidemiological considerations, and other pertinent and helpful data. This material reaches the physician usually on the first visit to him by a staff member of the VD Control Section. The material is also available to any and all physicians upon request.

A physician trained in the clinical and other aspects of the venereal diseases and their control has been assigned to South Carolina by the U. S. Public Health Service and is a staff member of the VD Control Section of the S. C. State Board of Health. His duties include conducting VD clinics over the state as the need is indicated, consultation with private physicians, VD research, and many other related activities. His services are available to the medical profession in the state at any and all times, through request to the VD Control Section of the South Carolina State Board of Health.

The Central Laboratory performed a total of 337,203 tests and examinations. In this figure are included 2,807 diagnostic procedures for viral and rickettsial diseases, an increase of 60% over those carried out in the year 1958. The methods used included those employed previously and, in addition, the use of chick embryo techniques with a limited number of materials cultured.

Of 158 cases of clinically diagnosed or suspected poliomyelitis, two-thirds of which occurred in the last six months of the year, 41 were confirmed as polio by laboratory findings. Other enteric virus infections demonstrated by the study of these cases with neurologic manifestations included Coxsackie, types A-9, B-2, and B-5 (38 cases) and ECHO, types 4, 5, 9, and 11 (5 cases). Throughout 1959, specimens were received from 84 cases to be tested for influenza, revealing six cases of infection with Influenza Virus Type A and 5 with Type B, of sporadic occurrence.

Of 599 animal brains examined for evidence of rabies by demonstration of Negri bodies, findings were positive in 21, or 3.7%. This represents a decline for the year 1959 as a whole, from 16.1% positive in 1958. A reversion of this falling trend in the incidence of rabies has been demonstrated toward the end of 1959, due to persistence and increasing prevalence of rabies infection in animals in several counties just northeast of the center of the State; and in December 1959 nearly 10% of animal brains examined yielded a positive diagnosis of rabies.

In testing specimens received from 33 counties for rickettsial diseases, no evidence of current or recent typhus fever was found. Three cases of Rocky Mountain Spotted Fever (Eastern type) were revealed, two occurring in the northwest portion of the State and one in the central portion.

In continuation and expansion of bacteriological work previously established in the field of preventive medicine, more efficient methods of shipping milk samples have been incorporated in the routine procedure, as a part of the split milk sample programs of the State and of the U. S. Public Health Service. Twelve milk testing laboratories throughout the State have been visited and inspected for evaluation in connection with approval for certification for interstate shipment of milk. Procedures established during the preceding year, including antibiotic testing, have been continued with preparation for expansion as needed.

In the activities of the bacteriological section of the laboratory devoted to the diagnosis of tuberculosis, 5,960 cultures were made, 92 of which received special study including sub-cultures to differentiate the typical tubercle bacillus, *Mycobacterium tuberculosis*, from atypical acid fast bacilli. Of these 92, 26 revealed atypical acid fast bacilli classified as Group III, nonphotochromogenic, from eight patients. Cytochemical tests used in these studies included the catalase, niacin and neutral red virulence tests. A series of evaluation tests has been undertaken on specimens submitted to the Laboratory by the Communicable Disease Center of the U. S. Public Health Service for identification of strains of *Mycobacterium tuberculosis*, atypical acid fast bacilli, and acid fast saprophytes.

Progress in work connected with control of venereal disease included representation of the laboratory at the annual Venereal Disease Seminar of the U. S. Public Health Service; and participation in the hospital survey program of the Venereal Disease Section of the State Board of Health, and in a special study of penicillin resistant strains of *Neisseria gonorrhoeae* in collaboration with the Venereal Disease Experimental Laboratory of the U. S. Public Health Service. The Laboratory has been designated as a collaborating laboratory in the World Health Organization Influenza Program.

A total of 42,887 tests and examinations were performed by the four district laboratories at Anderson, Florence, Spartanburg, and Walterboro, and the four county health department laboratories at Charleston, Greenville, Laurens, and Sumter. The activities of all the laboratories described were directed to providing services to county health departments, hospitals, individual physicians, and clinics needing these services to aid in the diagnosis, control, and prevention of diseases affecting the public health.

The enforcement of the laws governing the sale, distribution, and possession of narcotics, barbiturates and other restricted drugs, the Pharmacy Act and the Medical Practices Act has continued through the full time services of a drug inspector. As of July 1, 1958, the Augusta office of the Federal Bureau of Narcotics was elosed and the Agent in charge was transferred to another state. This left South Carolina without the services of a local agent and has greatly increased the duties of the drug inspector.

The majority of the retail pharmacies within the State have been inspected, along with numerous inspections in nursing homes and hospitals. Most irregularities found were of a minor nature and were corrected without legal action being necessary.

Thirty-two prosecutions were instituted during the year, of which twenty-five were for violation of the State Uniform Narcotic Act, four for violation of the State Uniform Barbiturate Act, and three for violation of the State Dangerous Drugs Act. Of the 32 prosecutions, 29 convictions were obtained, with three cases pending in the Courts. Of the persons convicted,

one was a physician, two were pharmacists, and two were nurses.

Seven physicians were found to be addicted to narcotic drugs and in each case the physician surrendered his Narcotic Tax Stamp and discontinued handling narcotic drugs. Case reports on each of these were forwarded to the Board of Medical Examiners for such action as deemed necessary. Reports on pharmacists and nurses involved in violations were forwarded to their respective licensing boards for proper action.

Of the defendants convicted, 13 received sentences totaling 26 years in the State Penitentiary, eight received fines totaling \$2100, and eight received probationary sentences totaling 29 years.

An educational program consisting of lectures before the senior classes of the two Pharmacy Schools and the junior class of the Medical College, also numerous addresses before Pharmaceutical and Nursing groups have been held during the year.

The State Board of Health for the fiscal year 1960 was allocated under the Hill-Burton Program (Public Law 725) the sum of \$3,814,696 and under the 1954 Amendment (Public Law 482) the sum of \$800,622.00 for a total of \$4,615,318.00. These Federal funds are to be used to pay part of the cost of constructing hospitals and related medical facilities.

The following tables will show how these Federal funds were distributed among the various types of facilities eligible for assistance under the program:

PUBLIC LAW 725

(The percentage distribution for this allotment was recommended by the Hospital Advisory Council and approved by the Executive Committee of the State Board of Health) In addition to the 1960 allotment of \$3,814,696.00, the unexpended reserve from 1959 in the amount of \$28,862.00 was added thereto for distribution.

Type Facility	Approximate Percentage Distribution	Allotted
General Hospitals	69.4	\$2,667,362.20
Tuberculosis	0	
Mental	13.0	500,000.00
Health Centers	10.0	384,355.80
Reserve	7.6	291,840.00
	100	\$3,843,558.00

PUBLIC LAW 482

(Allotment broken down by Congress)

Type Facility	Allotment
Diagnostic & Treatment	\$152,182.00
Chronic Disease Facilities	152,182.00
Nursing Homes	248,129.00
Rehabilitation Centers	248,129.00
	\$800,622.00

All of the 1960 Hill-Burton funds have been offered to eligible sponsors in accordance with the priority list set forth in the Revised 1959-1960 State Plan. These funds must be matched by the sponsors on a 50-50 basis and under contract by June 30, 1961. A sum of \$500,000.00 has been earmarked for the construction of an intensive treatment hospital at Whitten

Village, Clinton, and the project has been estimated at one million dollars. Federal funds have also been earmarked in the amount of \$100,000.00 for the Oconee Memorial Hospital project; \$450,000.00 to provide a chronic disease wing and to increase the scope of the Anderson Memorial Hospital project; \$248,111.00 to participate on a "fractional pickup" basis in the general hospital portion of the Greenville General Hospital project. Seven additional eligible hospital applicants have indicated their intent to file applications. Approximately \$300,000.00 of Federal funds under Public Law 482 are still on hand and available to eligible applicants for the construction of nursing homes, diagnostic and treatment centers, chronic disease facilities, and rehabilitation centers.

The Hospital Construction Section, in addition to the 1960 Federal funds discussed above, is also handling from previous fiscal year allotments 31 current Hill Burton projects with estimated costs totaling \$17,099,250.97. These projects will provide two completely new hospitals, McClellan-Banks Memorial Hospital and Oconee Memorial Hospital; eight ancillary facilities and/or bed additions to general hospitals, Spartanburg General Hospital, Anderson Memorial Hospital, Laurens County Hospital, York County Hospital, Divine Saviour Hospital, Marion County Memorial Hospital, Loris Community Hospital, and Mullins Hospital; four new public health centers, Florence, Charleston, Sumter, and Richland Counties; an addition to the Spartanburg County Health Center; ten new auxiliary health centers, located at Chesnee, Woodruff, Duncan, Landrum, Inman, Cowpens, Hardeeville, Denmark, Lake City and St. Stephens; a new mental health clinic for Florence-Darlington Counties; a chronic disease wing addition at Bamberg County Memorial Hospital; a diagnostic and treatment center addition at Greenville General Hospital; and a new nursing home at Marion Sims Memorial Hospital.

Final audits on twelve projects with costs totaling \$6,812,196.30 have been performed. These projects provided two complete new hospitals, Chesterfield County Memorial Hospital and Kershaw County Hospital; two ancillary facilities and/or bed additions to general hospitals, Georgetown County Memorial Hospital and Byerly Hospital; one new intensive treatment hospital and outpatient department, South Carolina State Hospital; three new public health centers, Orangeburg, Clarendon, and Cherokee Counties; one mental health clinic, Spartanburg; one outpatient addition at Columbia Hospital; one chronic disease addition at Divine Saviour Hospital; and one nurses' home and training school, Kershaw County Memorial Hospital.

Revised minimum licensing standards for hospitals and institutional general infirmaries, nursing homes and institutional nursing infirmaries, were approved and filed by the Executive Committee of the South Carolina State Board of Health with the Secretary of State on November 3, 1959. Under the hospital and related medical facility licensure program, the State

Agency currently licenses on an annual basis approximately 173 institutions.

In addition to specific responsibilities including the administration of rules and regulations and/or laws governing activities in the areas of water supplies, sewage disposal, food processing, bedding, milk, shellfish, bottling plants, and frozen foods, the Division of Sanitary Engineering has furnished on a cooperative basis consultation to county health departments on environmental sanitation problems. The explosive population increase and the ever-expanding industrial picture are posing real problems for this Division. With 30,000 new houses being built annually, most of which are in newly developed subdivisions, problems covering drainage, water, and waste disposal have been created. The Executive Committee, after thorough investigation, has approved the oxidation pond, or lagoon, for sewage treatment process as an acceptable method in subdivisions and small municipalities. This method of sewage treatment, under proper condition of design and maintenance, will accomplish outstanding results, and if land costs are reasonable, will accomplish a substantial savings in construction costs.

The State Board of Health, in cooperation with the Water Pollution Control Authority, has developed an effective Radiological Laboratory, designed to monitor the environment generally and to perform specific duties as may be indicated in connection with the utilization of radioactive material for any purpose throughout the State. This laboratory is cooperating with the Atomic Energy Commission, the U. S. Navy, U. S. Public Health Service, and the Virginia-Carolinas Nuclear Power Associates, Incorporated.

In the two latter instances, milk samples are being collected for radioactive content. Additional equipment has been purchased for this laboratory in order to comply with a request from the Navy authorities for a preliminary survey of the environmental factors in the Charleston area, preceding the establishment of the nuclear atomic powered submarine base. This equipment can also be used in connection with similar services in other areas of the State, such as the area concerned in the Parr Shoals development of the nuclear energy plant to be constructed there.

The Executive Committee passed a resolution approving the proposed bill providing for the control of radiation from machines and radioactive materials for the purpose of protecting health and requested that this bill be resubmitted to the Legislature. The disposal of radioactive wastes remains the most pressing problem in the field of industrial wastes treatment.

The State Board of Health has concentrated this year on its sanitary supervision in milk production and now requires that milk produced for sale shall not only meet Grade "A" standard requirements, but also shall come from herds free from brucellosis and tuberculosis.

The shellfish program has grown from relative insignificance to a prominent activity including sixty processing plants in operation in 1959. Constant sani-

tary checks are necessary to ascertain that the shellfish which are harvested and processed for sale come from sources free of contamination and are handled in a proper manner, in buildings constructed to meet the sanitary requirements of the South Carolina State Board of Health. All shellfish which are processed for human consumption must meet specific sanitary requirements both in and out of State. Shellfish not meeting these specific sanitary requirements are subject to confiscation by the South Carolina State Board of Health.

The Executive Committee has revised the rules and regulations to permit the bottling and packaging in milk pasteurization plants of non-carbonated non-pasteurized citrus fruit drinks.

Of interest is an amendment to an existing Legislative Act which prevented artificial sweetening of soft drinks. It is now possible to use such artificial agents as saccharin, etc., provided it is properly labeled.

An Air Pollution Control Committee of the Legislature has proposed legislation for the control of air pollution, administered through the Water Pollution Control Authority. Included in this report was a recommendation to reactivate the Division of Industrial Health within the State Board of Health. However, it was felt that the State Board of Health could not reactivate the Industrial Health Program at the present time due principally to a lack of office and laboratory space.

There is a strong liaison between the Engineering Division of the State Board of Health and the South Carolina Water Pollution Control Authority. All matters of mutual interest are discussed in the light of common benefit, leading to an appropriate solution for the betterment of health conditions throughout the State. The Authority has received 33 applications from municipalities in the State for permits to construct sewage treatment facilities. During 1959 the Authority has completed a re-survey of industrial and municipal waste outfalls into the waters of the State.

School construction and expansions in the State have resulted in the Division of Sanitary Engineering reviewing and approving 79 sets of plans this year as to their water supply, sewage disposal, kitchen accommodations, fly control, and general assembly features.

The Executive Committee has passed rules and regulations governing the addition of fluorides to drinking water which in the main require that any municipality, industry, water company, or individual operating a public or semi-public water supply shall add sodium fluoride, sodium silicofluoride or fluoride in any form to the water supply only after having obtained the written approval of the State Health Officer or his representative authorized to give this approval.

There are seventeen communities in the State that have added fluoride to their community water supply. Winnsboro (population 6,000) began fluoridation on June 2, 1959. Lancaster discontinued fluoridation in August. A referendum was held in Lancaster on De-

cember 1, 1959 and fluoridation won by a vote of 782-583. Fluoridation was reinstituted in Lancaster in December 16, 1959. Several cities in the State are now considering the addition of fluoride to their public water supply.

Carefully obtained facts and documents were made available in ample amounts to the citizens in potential fluoridation areas. The Director made personal appearances before all interested groups requesting information and counsel. Printed facts on fluoridation were furnished to newspapers, radio, television, and civic groups.

The Sodium Fluoride Mobile Team travelled to 23 schools for the purpose of applying topical applications of sodium fluoride to the elementary school children's teeth. Spartanburg, Richland, and Pickens Counties continued a permanent sodium fluoride program for the elementary school children in their counties. Permanent dental clinics were operated in the Spartanburg and Richland County Health Departments for the indigent children.

National Children's Dental Health Week, sponsored by the Division of Dental Health, in cooperation with the American Dental Association, the South Carolina Dental Association, and local dental societies, was observed February 8-14, 1959. Posters were supplied to all dentists, pediatricians and elementary schools for display. Dental Health kits, furnished by the American Dental Association, were sent to key personnel throughout the State to aid in the promotion of National Children's Dental Health Week. A brochure, "Careers in Dentistry," was mailed to all guidance counselors in the high schools. In cooperation with the South Carolina Dental Association and the American Dental Association, a series of articles on fluoridation were published in newspapers during the week. Spot announcements in dental health were used on the local radio and television stations.

The "Little Jack" Puppet Show played in the elementary schools in 32 counties. Thousands of children saw the show, which provides a healthy combination of entertainment and dental health instruction. Educational materials, such as posters, booklets, dental health films and a monthly newssheet ("Jack's Tracks") were sent to the elementary schools upon request.

As of December 31, 1959, there were 5,321 patients on the Crippled Children's Program. During the calendar year 1959, 11,113 clinic visits were made; 576 patients spent a total of 9,677 days in the hospital. This represents an increase of 78 patients hospitalized during the calendar year. 128 cases were closed as cured.

The Crippled Children's Division has continued its regular diagnostic and treatment services through its clinic, hospitalization, convalescent and appliance programs. The Convalescent Home has run at full capacity all the year.

The Executive Committee of the State Board of Health, upon the recommendation of the Director of Crippled Children's Division, and the State Health

Officer (because of shortage of funds) ruled that effective January 1, 1960, the Crippled Children's Division would no longer pay for transportation of crippled children. The yearly transportation budget has been \$20,000, which may now be used to better advantage for hospitalization and treatment of patients.

A Rheumatic Fever Clinic has been established in Florence on a monthly basis so that the cases in the Pee Dee area will no longer have to come to Columbia for medical care. The nurse and clerk from the Columbia Rheumatic Fever Clinic go to Florence to hold the clinic which is staffed by a local Florence pediatrician.

Arrangements have been made whereby the Chief of the Department of Physical Medicine and Rehabilitation of the Medical College Hospital makes rounds at the Convalescent Home in Florence once per month to give special attention to cases with long-term rehabilitation problems.

The Bureau of Vital Statistics registers and houses approximately 132,500 vital records annually. This represents an increase of approximately 64,000 vital records per year, or 93% as compared with the number filed per year in 1945. During this same period, the statistical activities of the department have increased more than 1500%. This is an extremely unusual accomplishment since during this period, the personnel of the Bureau of Vital Statistics has been reduced by 16.5%.

The department currently files in excess of 1300 amended certificates of birth per year for children who have been adopted, more than 500 amended certificates where the birth has been legitimized (where the father marries the mother after the birth of the child) and in excess of 100 certificates are amended annually through Orders of Courts of competent jurisdiction. As a result of attendants' failing to file birth records when the birth occurred, the department is having to file approximately 6,500 delayed records of birth per year. As a result of errors in original records, it is necessary for the department to correct approximately 15,000 certificates per year.

The reports of notifiable diseases are collected and compiled by the Bureau of Vital Statistics in cooperation with the Division of Disease Control weekly with a weekly telegraphic report and a monthly typed report being furnished the U. S. Public Health Service.

The department continues to strive to improve its statistical services to the medical profession, public agencies, industries, and civic organizations, resulting in the addition of the following tables to the annual Statistical Supplement now composed of 568 pages of statistical tables, for the first time: (1) Special five-year study of ten leading causes of death by occurrence, (2) Special five-year study of ten leading causes of death by residence, (3) Special study of deaths from all causes by residence ranked by age group, (4) Special five-year study of deaths due to infectious and parasitic diseases by residence, and

(5) Special five-year study of the principle causes of infant deaths by residence.

The Bureau of Vital Statistics maintains an up-to-date register of physicians in the State. The register is compiled both alphabetically and by county. This register is brought up-to-date quarterly through the cooperation of the county health departments, the South Carolina Medical Association, and through direct contact.

The county health departments are the basic service units in the administration of public health, providing their communities with all the direct services available through the specialized clinics operated by the State Board of Health, and other official and non-official agencies. While the county health departments are allowed ample scope for the initiative and creative activity of the health officer and his staff, the Division of Local Health Services has discharged its responsibility of assisting these departments in developing and carrying on a well balanced program of activities which included all the objectives of the State-wide public health program, and in addition, those objectives that were needed to meet specific health needs. Service was rendered in the allocation of State and Federal funds to the individual counties in keeping with the provisions of Appropriation Acts, assisting each county in the preparation and administration of its annual budget, and in justifying and securing local appropriations. Counties are kept informed of new laws and regulations pertaining to health.

The Division of Local Health Services has helped with recruitment, orientation, and training of personnel employed in the county health units. With the assistance of the State Supervising Nurse, the Associate State Supervising Nurse, and the Chief Sanitarian, county public health nurses and sanitarians have been given guidance in their local program planning of nursing and sanitation services.

Quarterly meetings of all health officers and administrative assistants have been held to discuss problems which the health officers themselves feel the need of discussing in groups where broad objectives and policies can be developed.

In-service training has been provided public health workers through workshops and conferences conducted by the various divisions of the central office and regularly scheduled district meetings.

At the present time nine counties are without health officers and are being served by administrative assistants who have been appointed to have administrative responsibilities for property, supplies, the signing of official communications, liaison with county delegations and with the public in matters concerned with public relations. The administrative assistants are under the guidance of the Director of Local Health Services. The remainder of the 37 local departments are served by 22 full time health officers and four part time health officers. (The county staffs consist of approximately 206 public health nurses, 100 sanitarians, and 129 full-time clerks)

This year a three-day orientation course for new

The South Carolina Heart Association

announces:

11th Scientific Session and Annual Meeting

GUEST LECTURERS



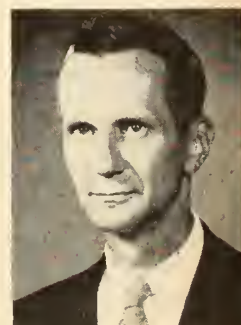
S. GILBERT BLOUNT, JR., M. D., Denver, Colo.



IVAN W. BROWN, JR., M. D., Durham, N. C.



R. BRUCE LOGUE, M. D., Atlanta, Ga.



OGLESBY PAUL, M. D., Chicago, Ill.

Morning Session

DANIEL W. DAVIS, JR., M. D., Columbia, S. C.
"Carotid Artery Occlusion"

R. BRUCE LOGUE, M. D., Atlanta, Ga.
"Carotid Artery Murmurs"

S. GILBERT BLOUNT, JR., M. D., Denver, Colo.
"Inter Ventricular Septal Defects—Diagnosis and Surgery"

IVAN W. BROWN, JR., M. D., Durham, N. C.
"The Physiology of Perfusion Hypothermia"

FRANKLIN G. HOFFMAN, M. D., Columbia, S. C.
"Adult Endocardial Fibroelastosis Associated with Dextrocardia and Complete Situs Inversus"

J. MANLY STALLWORTH, M. D., Charleston, S. C.
"The Clinical and Experimental Cardiovascular Effects of Commonly Used Vaso-Dilator Drugs"

Luncheon Session

OGLESBY PAUL, M. D., Chicago, Ill.
President, Elect, American Heart Association
"Helping the Heart"

Afternoon Session

EDWARD F. PARKER, M. D., Charleston, S. C.
"Cardio-Pulmonary By-Pass in the Treatment of Congenital Cardiovascular Disease"

R. BRUCE LOGUE, M. D., Atlanta, Ga.
"Subtle Signs and Symptoms of Congestive Heart Failure"

S. GILBERT BLOUNT, JR., M. D., Denver, Colo.
"Aortic Stenosis and Sub-Aortic Stenosis—Diagnosis and Results of Surgery"

IVAN W. BROWN, JR., M. D., Durham, N. C.
"Clinical Experience with Perfusion and Deep Hypothermia in Heart Surgery"

OGLESBY PAUL, M. D., Chicago, Ill.
"Some Findings in a Long Term Study of Coronary Heart Disease"

EUGENE F. WOODS, Ph. D., Charleston, S. C.
"The Influence of Reserpine on the Sympathoadrenal System"

C. FORD RIVERS, JR., M. D., Charleston, S. C.
"Cardiac Trauma"

SATURDAY, APRIL 23, 1960

Jefferson Hotel - Columbia, S. C.

REGISTRATION 9:00 A. M.

employees has been established. This course is held in Columbia every six months for the purpose of acquainting new employees with programs, policies, and procedures of the State Board of Health.

The Public Health Education Section has carried out educational and informational activities, providing consultative and direct services in methods and techniques of health education, and preparing and distributing all types of informational and educational materials for the divisions and sections of the State Board of Health, individual staff members, local health units, community groups and organizations, private physicians, and other individuals.

The year 1959 brought about the complete revision of the classification plan for employees of the State Board of Health. This was worked out through a committee whose efforts and overtime work are noteworthy of high commendation.

As of December 31, 1959, the Personnel Officer reports 890 persons employed by the State Board of Health. The duties and responsibilities of the personnel office were markedly increased during the past year due principally to policy changes and increased insurance payroll deductions, requiring the securing of additional help.

During the past year Mrs. Hettie Rickett, State Supervising Nurse, resigned due to illness. This position has been filled by a well-qualified and experienced public health nurse, Miss Maude Conway Bailey. A new position of Associate State Supervising Nurse has been established. Miss Virginia C. Phillips, who is also well-qualified and experienced, has been appointed to fill this position. In this respect, future planning includes the possible establishment of a Division of Nursing. This, however, will require considerable readjustment of existing programs, since many specialized nurses are now employed under several divisions of the State Board of Health.

Quick and accurate tabulations necessary to the operation of the State Board of Health have been made available through the punch cards and IBM tabulating machines in the Tabulating Unit. In 1959 the following items have been added to the IBM cards for tabulating purposes: (1) A quarterly State Retirement Report of State Board of Health employees is furnished the Finance Division for the State Retirement System, (2) Furniture and Fixture items purchased from State or Federal funds in 1959 and also items purchased with Federal funds since 1954.

The State Board of Health now has an administrative set-up with Business Management which is responsible for purchasing, distribution of supplies and drugs, the handling of insurance, leases, rents, mail, telephone service, physical maintenance and inventorying of its properties, and Finance, which is responsible for all accounting and financial records, certification of availability of funds for purchasing items, preparation of budgets and estimates of funds for State Health Officer, and payment of bills.

The total funds from all sources expended through the State Board of Health during the past fiscal year ending June 30, 1959, amounted to \$10,255,553.25.

EXPENDITURES SUPERVISED BY STATE

BOARD OF HEALTH FISCAL YEAR 1958-59

State	\$ 2,498,411.42
Federal	1,394,637.39
Local	1,062,939.44
Hospital Construction (Hill-Burton)	
Federal	4,277,040.00
Water Pollution Control (Waste Treatment Wks) Federal	1,022,525.00
Total Expenditures for Fiscal Year 1958-59	\$10,255,553.25

The promotion of better facilities and services for all newborn babies, with special emphasis on the premature, is a strong function of the Division of Maternal and Child Health. The Division is continuing to work closely with the Committee on Infant and Child Health of the South Carolina Medical Association in its special study on neonatal deaths in twelve hospitals in the State. This committee and the Division have developed a panel on "Perinatal Mortality" to be presented on the program of the State Medical Association in the spring. The preventive phase of perinatal mortality, to which prematurity contributes largely, will be stressed.

This Division has continued to plan for the overall supervision and training of midwives in the State. Two institutes for ten days each for their training were conducted at Penn School, Beaufort, in June-July, 1959. The approximate number of midwife deliveries is 14% and the number of midwives is being gradually reduced. Only 850 midwives were certified to practice in 1959.

A project has been developed by the Obstetric and Pathology Departments of the Medical College, the Maternal and Child Health Division of the State Board of Health, and the Berkeley County Health Department, whereby abnormal clinic patients are examined and followed through by the associate professor of obstetrics and his residents at bi-monthly clinic sessions held at the Berkeley County Health Department. Severely complicated indigent obstetrical patients are taken to the Medical College for treatment and delivery. Cytologic studies from the uterine cervix are also being evaluated by the Pathology Department.

With the steadily increasing number of hospital deliveries and the overcrowding of nursery facilities, our consultant nurse in obstetrics has spent a great deal of time assisting various hospitals in improving nursing techniques and standards of care for mothers and babies. The Division also continued to work with schools of nursing, particularly on obstetrical and pediatric curricula and nutrition education.

INFANT AND CHILD HEALTH COMMITTEE

The Infant and Child Health Committee has met three times during this year with excellent attendance and participation of the members.

The major work of the Committee has been in continuing a Neonatal Death Study initiated on January 1, 1958 in ten hospitals in the state. On January 1, 1960, this was expanded to include eighteen other hospitals. Some of the information derived from the study will be used in the program presented at the State Medical Association Convention in May at Myrtle Beach. Further reports of this work will appear in the *Journal*.

Following the direction of a resolution in Inoculations passed by the South Carolina Medical Association in May 1958, a meeting was held with Drs. McDaniel and Sheriff of the State Board of Health. A report of this meeting will be submitted to Council at a later date.

At the request of the State Board of Health, a sub-committee studied the Visual Screening Program which has been carried on by local health departments in ten counties with the cooperation of local doctors, PTA personnel, and the National Society for the Prevention of Blindness. Our Committee endorsed and recommended expansion of this program.

The leaflet, "Plastic Film—Correct Use And Misuse", was distributed by the State Board of Health with the cooperation and endorsement of our Committee to all physicians in the state.

Two members of the Committee attended the Ninth Annual Post-Graduate Obstetric-Pediatric Seminar at Ellinor Village, Daytona Beach, Florida, August 20-22, 1959.

The Manual of Resuscitation of the Newborn prepared by the American Academy of Pediatrics was supplied to each hospital in the state and to all physicians.

Since the By-Laws now give the Infant and Child Health Committee a continuing status, several projects currently under study will be reported on next year.

Respectfully submitted,

Dr. Fred F. Adams	Dr. Ethel M. Madden
Dr. Samuel O. Cantey	Dr. Joseph D. Thomas
Dr. Patricia A. Carter	Dr. Horace M. Whit-
Dr. William A. Hart	worth
Dr. Thomas G. Herbert,	Dr. Walter M. Hart,
Jr.	Chairman

INSURANCE COMMITTEE

The Insurance Committee held several meetings during the year, the first being on Wednesday afternoon, July 15th. At this time the Committee met at the Columbia Hotel in Columbia with the first part of the session devoted to a joint meeting with the State Committee of the Health Insurance Council. Representatives of a number of companies interested in writing health, accident, disability income and related coverage were in attendance, in addition to the members of the Association's Committee.

Common problems of the insurance industry and the medical profession were discussed, with consider-

able attention being given to the interest of each in maintaining a system of free enterprise and voluntary health insurance in the United States. The mutual desire for cooperation between the Association and the Health Insurance Council was voiced.

The Committee took final action in July upon the proposal which had been approved by the House of Delegates at the Annual Meeting in May, 1959, of a plan for professional liability insurance by the St. Paul Insurance Companies, and this was presented to all members of the Association last fall. While premiums charged for this professional liability coverage were initially approximately the same as those of other companies, there has been one general reduction to our members since the plan was put into effect. This reduction was announced on December 2, 1959, and reflected the following changes in premium rates: reduction for physicians from \$77.49 to \$66.15; for X-ray therapy from \$117.18 to \$66.15; for shock therapy from \$77.49 to \$66.15; and for partnerships from 25% to 20%.

Two other insurance plans for members of the Association were considered and approved by the Committee during the year, and the recommendation passed on to Council.

One of these was a plan for business expense insurance, whereby the cost of maintaining the physician's office, salaries of his assistants, etc., are paid during the period of illness or enforced physical disability. Proposals from two companies were received and the Committee, after careful consideration, recommended that of the Continental Casualty Company, represented by The General Agency of Charleston. One advantage of this type of insurance is that premiums are currently deductible for income tax purposes. This is not presently true with respect to premiums on regular disability income insurance.

The other plan considered by the Committee was one for high-limits (up to \$200,000.00) disability income coverage. This coverage, at an unusually low rate in the high brackets, is offered as a supplement to the usual disability coverage carried by most physicians under the group plan of the Educators' Mutual which the Association adopted several years ago, the individual policies with World Insurance Company, and others. Both the high-limits disability and the business expense coverage, on a group basis, were submitted to Council at its October meeting and were approved. They are now being offered to the members of the Association.

The foregoing covers the work of the Insurance Committee for the past year and we take some pride in the fact that through the efforts of the Committee, these three constructive additions have been included in the Insurance Program approved for the Association.

Respectfully submitted,

Clay W. Evatt, M. D.,	Frank C. Owens, M. D.
Chairman	Charles Zemp, M. D.
Richard W. Hanckel,	Joe P. Cain, Jr., M. D.
M. D.	



DR. ROBERT WILSON
SECRETARY

DR. HOWARD STOKES
TREASURER

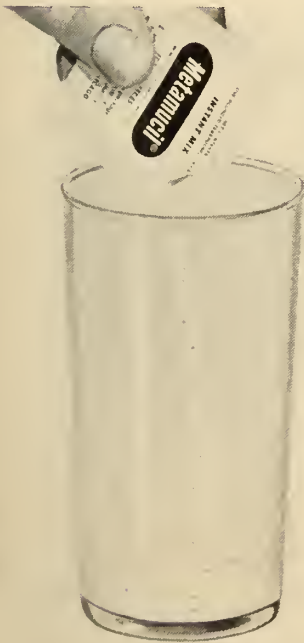


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SEARLE

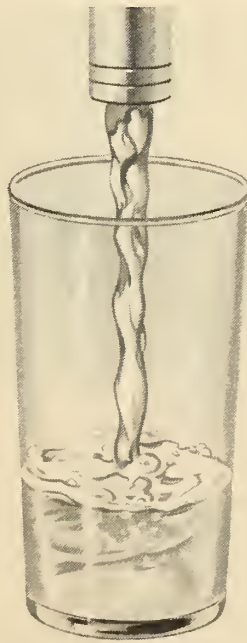
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Psyllium hydrophilic mucilloid with citric acid and sodium bicarbonate



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one packet*

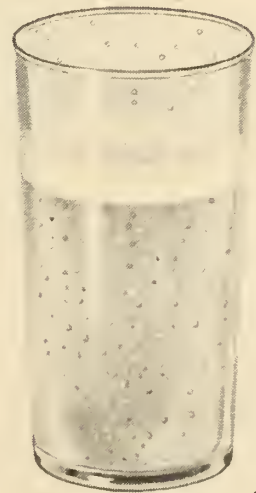
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each packet is equivalent to
one rounded teaspoonful of
Metamucil powder



*add cool water
slowly...
it's instantly mixed*

all the advantages of
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of constipation

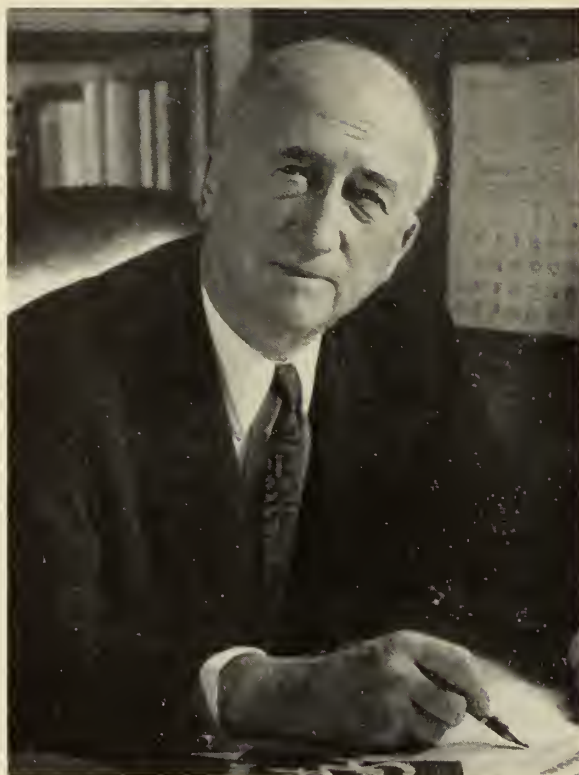
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stimulates normal peristalsis
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induces natural elimination
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promotes regularity
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HON. JAMES F. BYRNES, BANQUET SPEAKER

It seems superfluous to present to any South Carolina or national audience the essential facts of Mr. Byrnes' distinguished career. Born in Charleston, South Carolina, he has pursued a course which has brought him many important offices and responsibilities. Mr. Byrnes was admitted to the Bar in 1903 and for a time was Court Reporter, later becoming Solicitor for the Second Circuit. For several years he was editor of a newspaper in Aiken. In 1911 he entered the House of Representatives in Washington and remained for many years, subsequently becoming Senator in 1931. He practiced law in Spartanburg and entered into all of the important activities of the government of the state.

In 1941 he was made Associate Justice of the Supreme Court, resigning the following year. In 1945 he became Secretary of State of the United States and later, in 1951, became Governor of South Carolina. During the war years, he was Director of Economic Stabilization and later Director of War Mobilization, acting in an extremely intimate and important relationship with the President.

Mrs. Byrnes, who was Maud Busch, has been his life-long partner and has taken an essential part in his activities. Mr. Byrnes has written two books of autobiographical and reminiscent character, and devotes the proceeds from them to the education of young people.

The Association is fortunate to have such an eminent and able speaker.

PRELIMINARY REPORT OF THE WOMAN'S AUXILIARY TO THE SOUTH CAROLINA MEDICAL ASSOCIATION

As President of the Woman's Auxiliary to the South Carolina Medical Association, I wish to submit the following report.

"Individual Responsibility for Better Community Health" has been our National slogan for the year 1959-60. The state of South Carolina has chosen for its theme "Count Your Hours in Community Service". Each one of our approximately 840 members will give an estimate of her hours spent in Community Service, and it will be totaled at the end of the year. I feel confident that our state will rank amongst the top in these services.

AMEF is still our statewide project, and we feel that most of our AMEF projects will be completed this spring by our 18 county auxiliaries, and we can give a fairly accurate report on the amount from South Carolina by Convention time. So far it has reached approximately \$500.00.

Legislation is being covered very completely. Each auxiliary member has the printed brochure on the Forand and Jenkins-Keogh bills, and is standing by to write our Congressmen on any issue that may arise. At least five other organizations in each community have been contacted about medical legislation, and they also have been asked to write letters to our Congressmen. Our State Legislation Chairman is in constant contact with the National Chairman who alerts us at the opportune times to write.

Unfortunately the statewide Future Nurses' Club Rally which is held at Winthrop College in Rock Hill every February was cancelled due to the flu epidemic. There were 300 prospective applicants with a great program planned—the largest number of girls to ever apply. We had hoped to get a future date with Winthrop College. These girls are recruited while in high school and are taught some of the aspects of Nursing at these program meetings. Nurse recruitment is most important in this state and we are continuing to stress it. Our county auxiliaries send these girls from their respective communities throughout the state by bus, or either doctors' wives drive them.

Some of our auxiliaries give nurses' scholarships in addition to the State Loan Fund which is available to medical students and student nurses. Paramedical careers are also being included.

Our auxiliary members do all sorts of volunteer health service work such as Crippled Children's Easter Lily Sale, Red Cross, Civil Defense, Safety, Mental Health, and Public Health.

It is a pleasure for me to see the South Carolina doctors' wives working on these projects with enthusiasm, and I feel that by Convention time we will have a fine report to give.

We appreciate the interest and cooperation of the South Carolina Medical Association and we want all of you to feel free to call upon us at any time.

Respectfully submitted,
Mrs. John G. Ramsbottom
President

ANNUAL CONVENTION MYRTLE BEACH
MAY 17, 18, 19, 1960



Ocean Forest Hotel, Myrtle Beach, S. C.

WOMAN'S AUXILIARY SOUTH CAROLINA MEDICAL ASSOCIATION

PROGRAM FOR 1960 CONVENTION

MAY 17, 18, & 19, 1960

TUESDAY, MAY 17, 1960

- 2:00 P. M.—Student Loan Committee—Beach Home of President, Windy Hill Beach, S. C.
Mrs. M. J. Boggs, Chairman, Presiding
Paramedical Careers Committee
Mrs. Guy Castles, Chairman, Presiding
- 3:15 P. M.—Auxiliary Committee Meeting with House of Delegates, S. C. Medical Association—Ocean Forest Hotel
- 3:30 P. M.—Finance Committee—Beach Home of President, Windy Hill Beach, S. C.
Mrs. L. Hayne Taylor, Jr., Chairman, Presiding

WEDNESDAY, MAY 18, 1960

- 9:00 A. M. to 5:00 P. M.—Registration—Ocean Forest Hotel
- 11:00 A. M.—Executive Board Meeting—Eyerly's, Windy Hill Beach, S. C.
Mrs. John G. Ramsbottom, President, Presiding
- 1:00 P. M.—Executive Board Luncheon in honor of State Past Presidents, Eyerly's, Windy Hill Beach, S. C.
- 3:00 P. M.—Round Table Conference of County Presidents and Presidents-Elect, Eyerly's, Windy Hill Beach, S. C.
Mrs. George W. Smith President-Elect, Presiding
- 3:00 P. M.—Bridge Party at Home of Dr. & Mrs. B. L. Allen, Windy Hill Beach, S. C.
Hostesses, Spartanburg County Medical Auxiliary

THURSDAY, MAY 19, 1960

- 9:00 A. M. to 1:00 P. M.—Registration—Ocean Forest Hotel
- 9:30 A. M.—House of Delegates—Woodside Room, Ocean Forest Hotel
Mrs. John G. Ramsbottom, President, Presiding
- 11:00 A. M.—General Meeting—Ocean Forest Hotel
Mrs. John G. Ramsbottom, President, Presiding
- 1:00 P. M.—Sherry Party—Compliments of Cambridge Pharmaceutical Co., Greenville, S. C.
Eyerly's, Windy Hill Beach, S. C.
- 1:30 P. M.—Membership Luncheon—Eyerly's, Windy Hill Beach, S. C.
\$2.85 per person
Door prizes presented during Luncheon
- 8:00 P. M.—Banquet—Ocean Forest Hotel
S. C. Medical Association

Kay Workman (Mrs. B. J., Sr.)

Miriam Allen (Mrs. B. L.)

CONVENTION CHAIRMEN

The Journal

of the

South Carolina Medical Association

VOLUME LVI

May, 1960

NUMBER 5

THE ETIOLOGY AND THERAPY OF ESSENTIAL HYPERTENSION*

A REVIEW

ALBERT N. BREST, M. D.**

Philadelphia, Pennsylvania

JOHN H. MOYER, M. D.***

Philadelphia, Pennsylvania

The known causes of diastolic hypertension include a variety of hormonal, renal and neurologic disorders. Pheochromocytoma, Cushing's disease and primary aldosteronism are the usual hormonal causes. Renal hypertension may result from the nephritides, renal tumors, and congenital polycystic kidneys, and the various neurologic causes include intracranial tumors, encephalitis and tabes dorsalis. The most important contribution during recent years has been the increasing awareness of renal vascular lesions (e. g. atherosclerotic plaques) as important etiologic mechanisms for diastolic hypertension. Yet, in spite of the variety of known causes, the underlying etiology remains undetermined in the vast majority of hypertensive subjects. It is the purpose of this report to review the most prominent etiologic considerations in essential hypertension and to discuss their therapeutic applications.

Etiologic Considerations

Stress, heredity, neurogenic factors and disturbances in salt and water metabolism have long been considered to be important in the pathogenesis of essential hypertension. The speculative role of various humoral agents has also received prominent consideration; and, within the past several years, considerable

The authors discuss a variety of potential etiologic mechanisms including emotional stress, heredity, neurogenic factors, abnormal salt and water metabolism, humoral agents, and enzymatic disturbances. While they are free to admit that we lack tremendously exact knowledge of the etiology of essential hypertension, they believe that this disorder can be treated effectively, and they offer a comprehensive therapeutic regimen.

attention has been focused on possible enzymatic disturbances.

Stress. Every physician who has had experience with hypertensive patients is aware of the aggravating effect of emotional stress on the blood pressure level. It is also common knowledge that emotional crises may produce transient blood pressure elevations in patients who are normotensive under more tranquil conditions; and it is well established that the incidence of sustained hypertension is significantly increased among the latter group of subjects. Thus, although the mechanism remains undetermined, there is ample evidence that emotional stress plays an important contributory role in the pathogenesis of essential hypertension.

Heredity. All investigators agree that the incidence of primary hypertension among individuals with hypertensive parents is considerably increased. Hines has stated that when both parents have hypertension, the frequency of the disease in children rises to 90

* Presented by Dr. John H. Moyer at the Founders Day Seminar at the Medical College of South Carolina.

** Dr. Brest is Director of the Hypertension Unit.

*** Dr. Moyer is Professor and Head of the Department of Medicine, Hahnemann Medical College and Hospital.

per cent; and Platt has come to the conclusion, from a careful study of the blood pressure in hypertensive subjects and their first degree relatives, that the disease is inherited as a dominant characteristic. There seems to be little doubt that the hypertensive trait is either inherited or else is acquired in early life from the familial environment.

Neurogenic Factors. It has frequently been postulated that sympathetic overactivity accompanies not only true neurogenic hypertension but also the primary hypertension of man. Evidence in favor of this concept includes the known adverse effect of psychic stress on the blood pressure and the known therapeutic benefit of measures which inhibit sympathetic function. Yet, although it might be anticipated that a catecholamine excess would accompany sympathetic hyperfunction, catecholamine excretion is usually within normal limits in essential hypertension. Likewise a decrease in peripheral vascular resistance can generally be achieved by inhibiting sympathetic discharge with ganglionic blocking agents; however even after ganglionic blockade the peripheral vascular resistance of hypertensive subjects may remain higher than that of normotensives. These findings suggest that neurogenic factors cannot be the only ones involved in the pathogenesis of essential hypertension.

Salt Metabolism. Braun-Menéndez summarized the role of salt in diastolic hypertension with the following statement: "All the factors which favor the retention of sodium in the organism, whether due to an increased ingestion or a decreased excretion, facilitate the obtainment of hypertension". Certainly there is ample laboratory evidence to implicate the important role of salt metabolism in the hypertensive process. The administration of various steroids, particularly desoxycorticosterone acetate, plus the simultaneous ingestion of salt is one of the standard methods of inducing diastolic hypertension in animals. In addition Meneely and his group have shown that chronic ingestion of excessive sodium chloride alone will produce a pathologic process in rats that mimics human hypertension. However excessive salt feeding has been tried for short periods in normotensive adults with

negative or inconclusive effects on blood pressure. Thus the role of altered salt metabolism as a *primary* factor in essential hypertension remains inconclusive.

Humoral Agents. A variety of humoral agents including renin, vasoexcitator material (VEM), and serotonin have long been considered to be important etiologic mechanisms in the development of diastolic hypertension. Renin, which is released by the kidney in response to renal ischemia, has received the most prominent attention. This proteolytic enzyme acts upon an alpha globulin to split off angiotensin, which is a vasopressor agent. Hypertension may be induced experimentally by various manipulations of the kidney, e. g. the application of a clamp to one renal artery and removal of the contralateral kidney or the application of a membrane to one kidney and the removal of the contralateral organ. Therefore it is not inconceivable that renal ischemia could result from an organic process, such as pyelonephritis, and that a vasopressor substance might be released under these circumstances. However in essential hypertension there is no morphologic evidence of renal damage; and consequently the renal origin of this disease can only be speculative at this time.

Enzymatic Disturbances. The use of the monoamine oxidase (MAO) inhibitors in the treatment of essential hypertension has created considerable interest in the possible etiologic role of underlying enzymatic disturbances. The metabolism of the catecholamines has been of particular interest in this regard, since norepinephrine may either undergo oxidative deamination by monoamine oxidase or methylation by catechol-O-methyl transferase. However, available studies suggest that there is no significant deficiency of either major enzyme in essential hypertension; e. g., monoamine oxidase inhibition in hypertensive patients fails to produce any striking increase in the excretion of free norepinephrine. Nevertheless it is conceivable that an enzymatic defect limited to the receptor site might impair local degradation of the transmitter substance without producing a change in the overall metabolism of this compound. Considerable investi-

gative work still needs to be accomplished in this important area.

Treatment of Essential Hypertension

It is extremely fortunate that essential hypertension can be successfully treated even though its etiology remains undetermined. During the past decade there has been developed a large number of potent antihypertensive agents, including Rauwolfia compounds, ganglioplegic drugs, hydralazine, veratrum alkaloids, and the adrenergic-blocking drugs. The therapeutic actions of these compounds are directed primarily at the central mechanisms of sympathetic impulse formation or the peripheral sites of neurogenic transmission or both. (See Figure 1). The

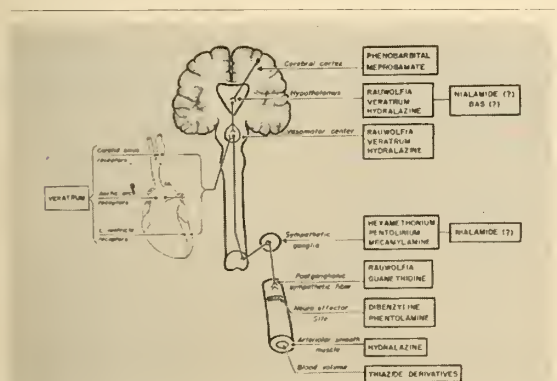


Figure 1. The pharmacodynamic sites of action of the various antihypertensive agents are illustrated in this diagram.

most important recent addition to the therapeutic armamentarium has been the thiazide derivatives which probably have local arteriolar vasodepressor action.

Rauwolfia Compounds. It is believed that depression of the sympathetic center in the hypothalamus and vasomotor center in the medulla is the major mode of action of these hypotensive agents. However these compounds also release (and thereby deplete) catecholamines from the peripheral postganglionic sympathetic nerve fibers, and this latter function is probably an important additional mechanism of action.

A large variety of Rauwolfia compounds are currently available including the single pure alkaloids of Rauwolfia serpentina (reserpine, rescinnamine and deserpidine) and various preparations containing multiple active

alkaloids (alseroxylon and whole root). There is statistically little difference in the hypotensive response obtained with these various derivatives. The major difference concerns the incidence of side effects which appears to be significantly less with the alseroxylon fraction (Rauwiloid) and the whole root (Raudixin) than with the others.

It is recommended that an initial loading dose of 8 mg. of alseroxylon or 200 mg. whole root of 0.5 mg. reserpine be given during the first two weeks of therapy, since this period of time is required before maximum effectiveness is obtained when the drugs are used orally. Thereafter these dosages can be reduced in half for maintenance therapy.

A variety of side effects may occur with the Rauwolfia compounds. These include nasal stuffiness, increased hunger, dizziness, and excessive drowsiness. However the most serious side effect encountered is an agitated mental depression, the first symptom of which is likely to be insomnia during the early morning hours. The insomnia may be followed subsequently by a sense of impending disaster and even suicidal tendencies. The earlier manifestations of this depressive state, including the insomnia, will frequently improve with dextroamphetamine (Dexedrine). However progression of these depressive symptoms must be considered an absolute indication for discontinuation of the drug.

Hydralazine. Hydralazine (Apresoline) is a rather unique peripheral vasodilator agent which produces prolonged dilatation of constricted vascular smooth muscle. In addition, hydralazine also depresses the outflow of sympathetic impulses from the hypothalamus and vasomotor center within the medulla. It is of interest that there is a maximal dose response curve beyond which further dilatation cannot be achieved even by huge doses of the drug.

The recommended initial dosage is 100 mg. daily (25 mg. after each meal and at bedtime). Thereafter the daily dosage may be doubled at weekly intervals until adequate reduction of blood pressure is obtained or the incidence of side effects becomes prohibitive. Total dosage generally should not exceed 400 mg. per day since the use of larger doses may be

associated with the development of severe side effects and particularly a mesenchymal lupus erythematosus-like syndrome.

The major untoward effects observed with hydralazine includes headache, palpitations, and increase in anginal symptoms (due to the associated tachycardia). When used in combination with thiazide derivatives or rauwolfia compounds or both, these untoward reactions are considerably reduced. Therefore it is recommended that hydralazine not be used as the sole antihypertensive agent.

Ganglionic Blocking Agents. These compounds are the most potent antihypertensive drugs which are currently available. Their mechanism of action is due to interference of neurogenic transmission within the sympathetic ganglia. Multiple preparations are available including mecamlamine (Inversine), hexamethonium (Bistrium), pentolinium (Ansolysen), and chlorisondamine (Ecolid). The approximate equivalent dosages of these drugs are 25 mg. hexamethonium, 20 mg. pentolinium, 12.5 mg. chlorisondamine, and 2.5 mg. mecamlamine.

Determination of optimum drug dosage is dependent upon effective drug titration. It is extremely important to start with a small dose of ganglionic blocking agent, and subsequently the dosage can be gradually increased until the standing blood pressure is reduced to the desired level. As a further guide to proper dose titration, the therapist should make use of available historical information. For example if the patient complains of attacks of dizziness occurring at specific times during the day, this indicates that he is obtaining an excessive hypotensive effect at that particular time.

Table 1 illustrates a method of drug titration for mecamlamine. Final dosage depends upon the criteria listed above. Because the drug action of mecamlamine lasts for a long period of time, the larger doses must be given in the morning and at lunchtime. However when the patient is relaxed in the evening, he does not require nearly as much. If the patient receives too large a dose at suppertime, he is particularly apt to experience hypotension upon arising in the morning.

Side effects encountered with these agents

Table 1. Method of Dose Titration of Mecamlamine (mg.)

Week	7 A. M.	12 Noon	5 P. M.
1st	2.5	---	2.5
2nd	5.0	---	5.0
3rd	5.0	5.0	5.0
4th	5.0	10.0	5.0
5th	7.5	10.0	7.5
6th	7.5	12.5	7.5
7th	7.5	15.0	7.5
8th	10.0	15.0	7.5
9th	10.0	15.0	7.5
10th	10.0	15.0	10.0

are due to the simultaneous inhibition of neurogenic transmission within parasympathetic ganglia. These untoward effects should be anticipated and properly treated; however they should not be feared. Constipation is the most common side effect and can usually be controlled with milk of magnesia (30 ml.) or cascara sagrada (10 to 30 ml. of the elixir) or prostigmine (15 to 30 mg). Likewise impaired visual accommodation and dry mouth usually improve with pilocarpine (5 mg. t.i.d.) and urinary retention can generally be controlled with urecholine (5 mg. t.i.d.).

Thiazide Derivatives. Several members of the benzothiadiazine family including chlorothiazide, hydrochlorothiazide, and flumethiazide have demonstrated potent hypotensive abilities. Their mechanism of action is uncertain; however, it is most likely related to the electrolyte imbalance which is induced at the local arteriolar level.

A recent study¹ indicated a significant blood pressure reduction in approximately 40% of the patients treated with each of the three thiazide derivatives described above. The usual dosage required is 500 mg. twice daily of chlorothiazide or flumethiazide or 50 mg. twice daily of hydrochlorothiazide. The incidence of side effects is low and approximately equivalent with all three drugs.

Maximum effectiveness is achieved when these compounds are used continuously rather than intermittently. In fact blood pressure will generally return to the pretreatment levels if these drugs are discontinued for a three day period. Sodium restriction should be practiced but should not be too rigid; specifically a daily salt intake of 3 to 4 grams is recommended. It has also been our experience that prophylactic electrolyte supplements (including po-

tassium) are rarely required if the dosages described above are not exceeded.

In addition to the blood pressure fall achieved with the use of the various thiazide derivatives singly, they also potentiate the effectiveness of all other antihypertensive agents. This attribute allows a reduction in dosage of the second drug, thereby reducing the side effects encountered with both. This effect is illustrated by the finding that the addition of chlorothiazide to a patient on ganglionic blocking agents generally allows a 25 to 50 percent reduction in dosage of the latter drugs.

Veratrum Alkaloids and Ganglionic Blocking Agents. Multiple veratrum alkaloids and adrenergic blocking agents are also available. However the use of the former group is limited by the development of nausea and vomiting which frequently accompanies effective dose levels; and the use of the latter agents (including dibenzylamine, regitine and benzodioxane) has been disappointing because of the numerous associated side effects and the rapid development of tolerance.

Comprehensive Therapeutic Regimen

A comprehensive therapeutic regimen is outlined in Table 2. It is recommended that one of the thiazide derivatives be utilized as the initial therapeutic agent (in the dosages described) because of their (1) effectiveness,

(2) relatively mild side effects, and (3) ability to potentiate other antihypertensive drugs.

If the thiazide derivative fails to achieve the desired response, a Rauwolfia compound should be added after one week. Thereafter if the blood pressure remains elevated after two or more weeks of combination therapy, hydralazine should be added according to the dose schedule described. Finally if the hydralazine is ineffective, it should be abandoned in favor of ganglionic blocking agents when the hypertension is of adequate severity to warrant the use of these compounds. In addition in those instances of severe progressive hypertension, ganglionic blocking agents should be added to the therapeutic regimen without delay.

Summary

A variety of potential etiologic mechanisms including emotional stress, heredity, neurogenic factors, abnormal salt and water metabolism, humoral agents, and enzymatic disturbances have been considered. Fortunately in spite of our lack of knowledge concerning the exact etiology of essential hypertension, this disorder can be effectively treated. A comprehensive therapeutic regimen is outlined.

REFERENCE

1. Brest, A. N. Therapeutic use of the thiazide derivatives in the treatment of essential hypertension. Hahnemann Symposium on Edema. W. B. Saunders and Co., 1959. In press.

Table 2. Comprehensive Therapeutic Regimen For The Treatment of Hypertension

Severity of Hypertension	Initial Therapy	Adjunctive therapy when not adequately responsive to initial therapy.
Diastolic blood pressure less than 120 mm. Hg.	Hydrochlorothiazide*	Rauwolfia
Diastolic blood pressure more than 120 mm. Hg. but less than 140 mm. Hg.	Hydrochlorothiazide* and Rauwolfia	Hydralazine or ganglionic blocking agent
Diastolic blood pressure more than 140 mm. Hg.	Hydrochlorothiazide* and Rauwolfia	Ganglionic blocking agent**

* Chlorothiazide or Flumethiazide may be used with equally good results.

** Must be added without delay when indicated.

CLINICAL INVESTIGATION OF TRIBURON*

IN PRIMARY AND SECONDARY PYOGENIC INFECTIONS

GEORGE C. SMITH, M. D.

Florence, South Carolina

What are the criteria for the ideal topical antimicrobial? Setting our sights on the pinnacle, we would say that such a preparation should 1) have activity against all types of infecting organisms, 2) cause no development of resistant organisms, 3) produce no irritation or sensitization in the patient and 4) be cosmetically acceptable. The last of these criteria seems to be fulfilled with most medications, but the first three enumerated are not so easily satisfied. Thus, penicillin has largely been discarded for use as a topical agent because of failure, according to criteria 2 and 3.^{1, 2} Resistant organisms have been found to develop following use of tetracycline and erythromycin.³ Neomycin has a rather narrow spectrum and an increasing incidence of sensitization, although it is effective against *Staphylococcus aureus*—the present “number 1” problem organism.³ Polymyxin B has an even more limited spectrum.⁴ Nitrofurazone, a chemotherapeutic agent, also has a limited spectrum, especially with regard to *Staphylococcus aureus*.⁵

This does not mean that these preparations should be discarded, but should rather be used with discrimination based on knowledge of their potential. Meanwhile, new agents which meet the above criteria should be sought.

It has been stated that chemotherapeutic agents are equally effective as antibiotics against superficial skin infections except those caused by monilia or pseudomonas,⁶ and that “The real value of the topical chemotherapeutic agents is that they avoid the development of organism resistance to antibiotics that may be required later for systemic therapy of much more significant infections.”¹

Triburon, a recently developed chemotherapeutic of the bisquaternary class, in *in vivo* tests was found to be more effective than neomycin, bacitracin, polymyxin B and nitro-

*Triburon—Brand of triclobonium chloride, Hoffmann-La Roche Inc., Nutley, N. J.

furazone against 5 strains of *Streptococcus pyogenes*. While penicillin was more effective against four strains, it was ineffective against a fifth. Triburon was equally effective as neomycin against seven strains of *Staphylococcus aureus* and more effective than the other drugs mentioned above.⁵ It has also been found to have activity against *Escherichia coli*, *Pseudomonas aeruginosa*, *Diplococcus pneumoniae*, *Listeria monocytogenes*, and *Salmonella typhi*.⁷ No evidence of sensitization or irritation was noted when the drug was applied liberally to large areas during burn and reconstructive therapy.^{8, 9}

A study was initiated to investigate the clinical response of Triburon in commonly encountered primary and secondary pyogenic infections.

Material and Methods

The study comprised 118 patients seen in a private dermatologic practice, most of whom were referred by their family physicians. The age range was from 3 months to 74 years (average 34 years).

In 68 patients Triburon cream, 0.1 per cent in a vanishing cream base, was applied to skin lesions of various etiologies; Triburon 0.1 per cent with 0.5 per cent hydrocortisone was used in 50 patients. Infections were both primary and secondary and included the following diagnostic categories: dermatitis of different types, folliculitis, blepharitis, pruritus ani or vulvae with secondary bacterial or monilial infection, ecthyma, impetigo, pyodermas, etc. (Tables I and II). All the chronic conditions were secondarily infected. The drugs were prescribed in a randomized fashion without regard to diagnosis because the active antimicrobial is present in both preparations.

A history of the particular lesions extended over a period of from one day to 7 years. Previous therapeutic measures included ultraviolet light, x-ray, Burow's solution soaks, steroid therapy and bichloroacetic acid.

TABLE I
Results of Treatment with Triburon Cream

Diagnosis	No. of Patients	RESULTS				
		Excellent	Good	Fair	Un-improved	No Follow-up
Ecthyma	5		3			2
Excoriations, neurotic (infected)	2		2			
Dermatitis, secondarily infected:						
Atopic	1		1			
Bullous	1		1			
Contact	3	2	1			
Venenata	1	1				
"Id"	1		1			
Seborrheic	14	2	9		1	2
Stasis	2		1		1	
Folliculitis	4	2	2			
Monilial infections	7		7			
Pruritus vulvæ	1		1			
Pyoderma	7	4	3			
Urticaria with excoriations and infection	2	1				1
Tinea pedis with secondary infection	2		2			
Mycosis fungoides with secondary infection	1		1			
Impetigo	2	2				
Larva migrans with secondary infection	1	1				
Miscellaneous dermatoses with secondary infections	11	6	4		1	
TOTALS	68	21 33.3%	39 61.9%	0	3 4.8%	5

TABLE II
Results of Treatment with Triburon plus Hydrocortisone

Diagnosis	No. of Patients	RESULTS				
		Excellent	Good	Fair	Un-improved	No Follow-up
Blepharitis	3		3			
Dermatitis, secondarily infected:						
Allergic	3	1	1		1	
Contact	5		5			
Eczematous	2		2			
"Id"	1	1				
Neurodermatitis	2		2			
Seborrheic	6		6			
Papillaris capilliti	1		1			
Folliculitis	2	1	1			
Pruritus (ani, vulvæ with secondary infection)	5	1	3			1
Monilial infections (dermatitis, intertrigo)	4		2			2
Pyoderma	3	1	2			
Tinea (corporis and pedis, secondarily infected)	2		1		1	
Rosacea with pustules	2		2			
Miscellaneous	9	2	5		1	1
TOTALS	50	7 15.2%	36 78.3%		3 6.5%	4

The cream was prescribed for application by the patients 3 times daily in 12 instances, twice daily in 104, and once daily in 2. Treatment varied mainly between 2 days and 3

weeks although some patients were treated for longer periods. Careful instructions for use were given. The patients were told to discontinue the drug if any irritation occurred or

if there were no improvement within 7 days. Results were considered to fall into four categories—excellent, good, fair and unimproved. Subjective and objective observations were evaluated. When the primary infection was of bacterial origin such as in impetigo, ecthyma, or folliculitis, results were considered excellent if there was a complete clearing of the infection; good if the infection was more than 50 per cent but not wholly cured. In the secondarily infected dermatoses results were considered excellent if the secondary infection cleared completely and the primary condition improved; good if the bacterial infection cleared or improved considerably but with no remission of the primary lesion. Fair and unimproved in both categories indicated either minimal improvement or no change.

Results

Of the patients treated with the plain cream, 21 had excellent results, 39 good, 3 were unimproved and 5 did not return for evaluation. In the Triburon-HC group, 7 had excellent results, 36 good, 3 did not improve, and 4 were lost to follow-up.

In all cases where the lesions, either primary or secondary, were of bacterial origin, the response was good or excellent; the monilial infections were also greatly improved in all instances; of the 4 tinea and 1 parasitic infections, the fungus and parasites were unaffected by treatment, but in the 4 with secondary bacterial infections control of these latter infections was excellent, improvement usually occurring in 1 to 2 weeks.

In the few cases where itching was a troublesome feature, the choice of cream seemed inconsequential. In some patients in the hydrocortisone group, itching was controlled, while in others it was not; the same was true with the plain cream.

Only one patient developed a reaction following application of the cream. She had been using it for some time on an ulcer prior to the onset of a contact type of reaction. A patch test was negative with Triburon cream 2 weeks following discontinuance of medication.

Several interesting case studies are given below:

Discussion

How does Triburon meet the specified criteria? Its effect on bacterial and monilial infections was satisfactory, but tinea infections were not improved; sensitization or irritation was not apparent, even when used in ophthalmologic conditions; it was cosmetically acceptable; resistance did not develop even in the patients treated for protracted periods although a longer, more intensive study would be required before positive conclusions could be drawn on this point.

My own personal observation as a dermatologist is that Triburon is superior to most of the antimicrobials that I have used topically. Clinically the response was good in a high percentage of the patients, and there were no true sensitization reactions.

A comparison graph of the results with Triburon and Triburon-HC is included in Figure I.

Summary

Of 118 patients with primary or secondary pyogenic infections 28 had excellent results following the application of Triburon or Triburon-HC, 75 achieved good results, 6 were treatment failures and 9 were lost to follow-up. Improvement was noted in 95.2 per cent of the patients who used the plain cream and in 93.5 per cent of those who used Triburon with hydrocortisone.

In general the bacterial and monilial infections showed a good response but tinea infections failed to respond to therapy.

Triburon appears to be an excellent agent for the treatment of primary and secondary pyogenic infections.

Case Studies

L.B., a 42-year-old male when first seen by us for contact dermatitis of 6 months' duration, had a severe flare-up of the condition with bullae and pustules on the hands and arms. Previous treatment had consisted of ACTH, x-ray, Decadron, aureomycin cream, Burow's soaks, Aristocort (triamcinolone) and Polysporin (polymixin B sulfate and zinc bacitracin). Triburon cream was prescribed to be applied to the areas twice daily. Clearing of infection was noticeable within 4 days and progress continued until complete disappearance was achieved after 4 weeks. There was no evidence of side effects.

B.W., a 19-year-old married female had monilial dermatitis of the perivulval area, which extended on to the thighs and the rectal area. The condition had been

present for 2 months. Cultures showed the presence of *Candida albicans*. Topicort, Calmitol lotion and quartz light had been used without effect. She was told to apply Triburon vaginal cream to the area twice daily. In 1 week considerable improvement was noted.

J.C., an 18-year-old female with contact dermatitis, superimposed neurodermatitis and pyoderma with a history of recurrence for several years presented the following picture on the initial visit: two eczematous patches on the dorsa of each great toe and a reactive area on several of the toes of both feet, crusted and showing pustules. During the previous week, a papulo-squamous dermatitis appeared about the posterior thighs and back which suggested an "id" type reaction following secondary infection. Triburon cream was applied three times daily to the feet. At the end of one week there was good progress, with all areas of

infection clearing. By the end of the second week the secondary lesions were completely healed, leaving the lichenified dermatitis. The combination of the steroid and Triburon helped to control both infection and pruritus.

E.H., a 36-year-old male, had pruritus ani of 2½ months' duration. The perianal area showed a moderate monilial type dermatitis and mild fissuring. Triburon-HC was applied twice daily. In 2 weeks the area was entirely clear.

E.H., a 30-year-old female had a chronically recurring blepharitis. The present episode was of 2 weeks' duration when Triburon-HC was prescribed to be applied to the eyelids twice daily. On the second visit two weeks following the initial visit, the response was noted as excellent. There was no evidence of side effects.

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Normal systolic murmur. Dale Groom, Waddy Chapman, Wofford W. Francis, Anne Bass, Yro T. Sihvonen (Charleston) Ann. Int. Med. 52:134, Jan. 1960.

The presence of functional systolic murmurs in some adults has long been recognized. Of recent interest is the finding that these murmurs can actually be recorded from the precordium in virtually all normal subjects.

By means of a high-sensitivity (capacitance) pickup in a soundproof room, recordings were made on a cathode-ray oscilloscope from 71 normal adult subjects. Only those with a negative past history of a heart murmur or heart disease were included, and in none of them was a murmur audible on ordinary stethoscopic auscultation. Recordings were made with the subject at rest in the supine position.

All subjects showed readily discernible murmurs extending through one-fourth or more of systole and reproducible on repeated tracings. In more than three-fourths of the subjects the point of maximum intensity was between the 2nd and 4th intercostal spaces along

the left sternal border. Wave forms of most murmurs showed some sinusoidal characteristics with fundamental frequencies of 60-90 c.p.s. and secondary frequencies an octave or more higher. The majority of the murmurs were of decrescendo configuration following the first heart sound; only about one-third had a diamond type pattern. Their intensity tended to vary from day to day, with different phases of respiration or changes in position, and with exercise. Short diastolic sounds followed the second heart sound in a few of the subjects.

Using the same technique, murmurs were found in 19 of 25 fetal hearts recorded during the last trimester of gestation. Quite likely a fetal murmur is normal but arises from shunts unique to the fetal circulation.

The mechanism and site of origin of these systolic sounds in the adult is uncertain. However, their presence is understandable on the basis of what is known of circulatory dynamics, and it appears that they represent a universal functional murmur which is usually subaudible.

AESCULAPIUS IN THE MAKING

LELAND S. MCKITTRICK, M. D.

Brookline, Mass.

Doctor Lynch has given me complete freedom in the selection of my subject for tonight. Since it is not too difficult to discuss a subject in which one is deeply interested but about which one knows very little, I have chosen to comment briefly on the several phases in our overall program of medical education.

The young man or woman who holds a degree of doctor of medicine from one of our medical schools has an educational background which offers more opportunities for self-expression and for a satisfying life than is associated with any other graduate degree. The desire to do research at the basic or clinical level; to care for the sick; to teach, or any combination of these may be easily fulfilled by the necessary accentuation in depth in the desired area.

As a surgeon contemplating a given operation and in discussing it with the patient I always like to delineate and then to evaluate a definite objective; or put in another way, I like to plan in terms of what I expect to accomplish by my undertaking. Permit me then to discuss our educational programs in terms of the kind of a product we are trying to develop.

Whatever may be the interests of a college student preparing to enter medical school, his undergraduate medical education should be developed on the assumption that he, as a physician, will devote at least a part of his time to the care of the sick.

With proper selection of students, and an educational program thus oriented, the medical school graduate may be expected to have certain qualifications not commonly developed in the population at large. He should possess more than just a scientific training of high order. He must be interested in people as people not as the harborers of disease. He must like to work with them as individuals and as members of the community. He should

be of higher than average intelligence; he must possess curiosity, imagination and be able to think, reason, deduct and express himself with clarity. He should have an alert, orderly, selective and retentive mind — one which permits him to distinguish the important from the unimportant and to critically and logically evaluate his own mistakes as well as those of his colleagues, storing only the essential facts for recall immediately, in six months or ten years hence should the occasion demand.

Completely honest, he must have the courage to tell a patient "I don't know" but a sense of responsibility and a curiosity that will stimulate him to use every means to find out; and if he is to command the respect of his colleagues, patients and their families, he must—with justification—believe in himself and manifest to others those qualities which inspire in them the confidence so necessary to the management of a critically ill patient.

This is not too big an order to shoot for. Accomplishment, however, presupposes the selection for medical school of those who possess the necessary qualities; and then our ability to nourish and bring these to full fruition.

The selection of the best students for a medical education is a difficult task. From the pool of applicants, selection must be unhampered by geographic or other restrictions. Even then the choice is not easy. It was once my privilege to serve on the Admissions Committee of the Harvard Medical School; the committee of the Massachusetts General Hospital responsible for the selection of eight candidates for the five year training program in surgery; and, at the same time, on the American Board of Surgery. Even after thoughtful consideration of all of the information before us we made mistakes at all three levels.

As with all admissions and intern committees which work without restrictions, we tried very hard to select from fairly large

Founders Day Address, Medical College of South Carolina, Charleston, S. C., November 5, 1959.

pools the best qualified candidates for a limited number of places. We knew what these young people had done, we knew what they were doing, yet all too frequently we failed to estimate their capacity to develop in keeping with the long and demanding educational program ahead.

It is with the above as a background that I would like to make a few comments on the several levels of education through which the physician passes.

College Education

I would like to see the term "pre-medical student" disappear both in name and in fact. The student contemplating a career in medicine should not be considered apart from other college students. What we want in medical school are intelligent, motivated, educated young people who have the capacity, the interests and personal qualifications to become physicians.

College, at the present time, prepares few, if any, for their life's work. Each holder of a bachelor's degree should have a good, well rounded education; a background of information which will permit its holder to live with understanding and enjoyment in a complicated world and which will prepare him to continue with additional training in his chosen field.

I do not know that I really understand what I mean by a "well rounded education". I would feel quite secure in saying that it means learning in breadth as well as a certain degree of depth in some areas. I would feel that unless the individual in addition to the humanities, knew something of the world from which we came and in which he now lives, he would not be called educated. Mathematics, the biological, physical and chemical sciences are so essential to an understanding of what we see, hear and read that the prospective student of medicine need have but little more depth in the scientific components of his college education than should the college graduate who becomes the teacher, the lawyer or the mother.

Medical school and medical practice are selfish and demanding masters, allowing little or no time for the development of interests in other fields, yet permitting the pursuit of those already acquired. The modern university is not only the center for almost unlimited ed-

ucational facilities but offers tremendous opportunities for self-evaluation or testing, if you will, of one's various non-academic capabilities and for the development of those dormant qualities needing only the stimulus and opportunity to grow.

Possibly active participation in activities which are not strictly academic but which are demanding of a certain amount of discipline, initiative and sustained application, together with a satisfactory scholastic record may be a better measure of capacity than a high scholastic record alone. It is from those who have found in college and have utilized opportunities such as these that I would like to think most of our medical students will come.

Medical School

Not too long ago in discussing some of the facets of medical education one of our leading educators asked: "What happens to the idealism of most medical students between the time we take them into our medical schools and they enter the practice of medicine?" I cannot answer this question. I doubt, however, that much of anything happens to it—and maybe that is what is wrong. Most prospective medical students on interview will say that they are scientifically oriented and like to work with people. I have always believed that there is more idealism in the entering class of a medical school than in a cross section of the senior class of any of our colleges, and I see no reason to believe that this idealism has been lost. Yet it is not a dominant characteristic of the young physician about to enter medical practice today. Medical schools and the period of graduate training have developed their scientific and technical skills, but except in rare instances have done little to develop these young men and women as individuals.

I am too realistic to believe that young people, except for a very few, go in to medicine for humanitarian reasons alone. Medicine permits them to make a good living while doing the things they most enjoy. If, on planning our educational programs, we fail to recognize the importance of the economic aspect of medicine we will neglect one of the basic factors influencing the life of the physician.

The primary objective of our medical schools is the education of physicians of high caliber and in such numbers that the people of America are and will continue to be assured of medical care of high and ever improving quality.

Research is an essential but not the most important component of our overall program. In these days of lay and professional emphasis on research, and with Federal and private funds readily available, it becomes imperative that our medical schools keep constantly before them their primary responsibility of educating and training physicians. Research may be and probably is a most important tool in the accomplishment of this objective but it must not be permitted to become the driving force behind the school.

Medical School no longer prepares its graduates to enter directly into the practice of medicine. We know that at least two years and probably more following graduation from medical school represents the minimum additional training that the young physician should have before accepting his responsibilities in the community. We all recognize the tremendous job that is being done in teaching the basic sciences and in giving a good background in disease and patient care. The graduates of most of our medical schools today have had clinical experience comparable to that which followed one year of internship two decades ago. But the medical school should do more than teach the basic sciences and give to its graduates an understanding of the broader aspect of medicine. It should stimulate and encourage the inquiring mind, carefully guiding it in the fascinating realm of research but along with this must come the development of the individual. But how do we teach or inspire young people to think, to reason, to accept responsibility and to show the understanding and the maturity which we have reason to expect in the holder of the M. D. degree? Certainly not by the continuation of a tight schedule of lectures, laboratory classes and examinations under a discipline comparable to that of college. The imagination, the curiosity and the humanity within each student must be stimulated and developed at the same time during which he is learn-

ing the innumerable essential scientific facts. Somewhere, somehow, there must be a transition between the boy who follows a prescribed course and the man who thinks and reasons and keeps growing.

I am sure that all of you, just as I, can look back at certain experiences in medical school which did something to us as people. Two such immediately come to mind. The first happened in my freshman year in the University of Wisconsin. It was on the occasion of our first examination in physiology. Dr. Walter J. Meek (if my memory serves me correctly) appeared before the class and in simple words told us that one of the fundamental characteristics of a doctor was honesty. He would expect no less from each of us. Every year it had been customary for the freshman class to vote for or against the honor system; the vote must be unanimous and if in the affirmative it was the responsibility of the class to see that it was carried out in fact as well as in spirit. As expected, it was approved. He then passed out the examination questions and said that he would be in his office next door should any one wish to see him.

That experience did something to me as I am sure it did to every other member of the class. All of a sudden I seemed to have grown up. I was given a responsibility I had not known before.

Another incident occurred in my third year after transferring to Harvard Medical School. At that time all except the complicated obstetrics was carried out in the patient's home by the third year medical students. We bought our doctor's bag, a small sterilizer, some rubber gloves, a few instruments and for three weeks moved into what we called "The District". There was a house mother who took care of our sleeping quarters and the telephone calls. We saw and delivered the patients in their homes. I was "Dr. McKittrick". Most of these patients had been carefully followed in the prenatal clinic by the teaching staff—yet to all intents and purposes mother and baby were our responsibility until the cord had dried and the mother was well along. If there were any complications we were expected to follow the baby or the mother until both were ready for discharge even though our tour of

duty was over. Coming into the home, as we did, we not only assumed responsibility for the mother and young baby, but seeing these people in their homes—how they lived and their response to illness (if this can be called illness) we developed a deep sense of responsibility to the entire family as well as to the mother, the baby and to our supervising obstetrician.

Medical school is a gathering of serious, intelligent, motivated young men and women. Somehow, somehow, along with the tremendous pressure of learning the basic sciences and the sciences of disease we, in our changing curricula must work out through free time and by positive effort a mechanism for developing those personal and intellectual qualities which we associate with the physician.

Graduate Education

Specialization is the vogue. Specialism has contributed much to research, teaching and patient care. Specialization, properly controlled and coordinated will continue to be an essential part of our over all program of medical education and medical care. However, there are many who feel that the time is rapidly approaching—if not already here—when the relationship between specialty boards and our overall program should be carefully re-evaluated.

The boards have developed more or less like Topsy. Once approved by the Council on Medical Education and Hospitals a board becomes an independent agency with no central coordinating influence. With each board setting its own requirements for certification, graduate education has become almost completely dominated by the specialty boards. Just what influence the residency review committees may have in directing our future educational plans time only will tell.

It is my own feeling that many of the boards, in the surgical specialties at least, have not kept pace with the overall progress in surgery.

The gynecologist is doing hysterectomies with pelvic node dissections as well as doing pelvic exenterations;—the urologist is making ileal bladders, working in the abdomen, through the chest or both; and the otolaryngologist is going from the late mastoid-

ectomies to radical head and neck surgery. These are developments in general surgery, not in the specialty *per se*. Yet the board requirements for training in the broad aspect of surgery are not adequate to meet the demands of surgical procedures of this magnitude.

I believe that the surgical specialties should be more closely aligned with general surgery and that as in chest surgery, the gynecologist, the urologist or the otolaryngologist should look forward to a coordinated program of training which will qualify the graduate for certification by both the American Board of Surgery and the specialty board. The overall lapse of time would be little if any more than is now required. The end product would be a specialist in every sense of the word.

There is a compelling need for a large segment of our medical school graduates to assume responsibility for the comprehensive care of the family. Properly prepared with a good background in medicine in its broadest sense, pediatrics, care of the new born and uncomplicated obstetrics, such an individual could probably do an excellent job in caring for most of the needs of the American family. A committee under the Council on Medical Education and Hospitals of the American Medical Association worked for two years developing an educational program designed to train physicians to meet the responsibilities. Its recommendations were approved by the House of Delegates last June. It now remains to be seen whether new programs in keeping with the spirit of the committee report will be developed. If this is done a new era in graduate education and medical practice may be ahead.

Postgraduate Education

The physician's education never ceases. New knowledge, changing conditions, new methods of treatment, all make it essential that the physician, throughout his active life, will remain a student. Each must develop for himself some method by which he will give to his patients the benefits of the newer developments in the science of medicine.

Hospital conferences, postgraduate courses, scientific meetings and current medical literature offer the more common sources of information.

Unfortunately much which appears in our current literature needs careful evaluation and that which is really good may be widely distributed in a variety of journals and not readily available to the busy physician.

I know of no mechanism by which the busy physician, whether he be in general practice or in a specialty, can so easily and effectively keep abreast of the important practical developments in medicine as by regular attendance at the scientific exhibits of the Annual Sessions of the American Medical Association. Here under one roof is brought together an unbelievable array of information. Here, too, the physician may see, read, and discuss informally the subject matter as it pertains to his individual practice.

But it is the intent and the result, not the methods chosen that count. When the physi-

cian loses his will to learn, he forsakes the confidence of his patients.

* * *

"The office of a Physician is the highest that one man can confer upon another; an office of the greatest trust. What availeth a large estate, nay a crown or scepter to one languishing under a fever, or distracted with torturing pain. The noble art of Physic excels all other arts and sciences; and those gentlemen, who have the honour of that profession, should shew the dignity of their office by the shining characters for true religion, humanity and learning; they should not stoop to do a mean thing; never refuse to give advice to the poor, nor make a property of the rich."*

*A New and General System of Physic In Theory and Practice, by William Smith, M. D. Printed for the Author and Sold by W. Owen in Fleet-street. M. DCC. LXIX.

Anticholinergic anesthesia. Clarence W. Legerton (Charleston) South. M. J. 52:927, Aug. 1959.

This paper presents the thesis that the major use of the anticholinergic drugs in peptic ulcer disease lies in their ability to relieve acute ulcer pain. Since this effect is achieved by abolition of abnormal motility rather than by decrease or abolition of acidity, it follows that these agents do not contribute any more, proportionately, to the healing of the ulcer than do older established methods of ulcer therapy.

This relief of pain may lead both the physician and the patient to omit these other aspects of ulcer therapy or to stop their use too early.

Since ulcer pain can be masked by these agents, their use prophylactically or in the long-term management of the ulcer patient is unwise. Mild recurrences may be anesthetized, and with the warning symptom of pain not present, recurrences may not be recognized until a complication occurs. Thus this masking of pain may actually be harmful, allowing complications to occur that could have been prevented had adequate ulcer treatment been begun when pain first appeared. It is known that the anticholinergic agents do not prevent complications nor do they obviate the need for surgery.

The author feels that the absence or decrease in ulcer recurrences on long term therapy with these agents is due to failure to recognize the recurrence due to the absence of pain, and not to the fact that the anatomical crater has not recurred.

Summary of preoperative factors in production of cardiac arrest, by William E. Bomar, Jr., W. R. Thompson and J. D. Ashmore, Jr. (Greenville) J.A.M.A. 172:41-43, Jan. 2, 1960.

A study of 30 cases of cardiac arrest, while limited in scope, points to the lesser importance of anesthetic factors in production of cardiac arrests since the majority of cases exhibited serious pre-existing disease either of an organic or metabolic nature. The poor survival rate of patients in this and other series emphasizes the grave nature of such accidents. The need for a study of this problem on a national level is stressed, and it is recommended that all people concerned with operative care of patients be familiarized with the methods of resuscitation.

The retinopathy of arteriosclerosis by J. W. Jervy, Jr., M. D. and E. D. Jervy, II, B. A. (Greenville) Tristate Med. J. 7:9 (June 1959)

A short description of changes in the retinal vascular tree in arteriosclerosis is given and a limited review is made of pertinent recent literature. Several points of general interest are brought out. Of special interest is a report of Alpers, Foster, and Herbert who found that while the absence of arteriosclerosis in the retina is of no value in determining whether there are arteriosclerotic changes in the cerebral vessels, the presence of these changes in the retina gives a 6:1 chance that they are also present in the brain.

THE GREENVILLE COUNTY MEDICAL SOCIETY HISTORICAL SKETCHES

THE MODERN ERA

J. DECHERD GUESS, M. D.

This is the ninth and last of a series of articles, adapted from the book *A Medical History of Greenville, South Carolina*, written by the same author, and which was published by the Greenville County Medical Society in 1959.

The beginning of each era in Greenville's medical history was clearly delineated by an important event. The first era began with peace after the American Revolution. It ended with the Civil War. The second era began with Reconstruction and ended with World War I. The third era followed World War I and continued through World War II. The fourth, or modern era, followed World War II.

The beginning of the modern era was characterized by several important happenings. With the election of Dr. Tom Brockman to the presidency of the Greenville County Medical Society, there began a modernization and activation of the society as a scientific body. The programs were changed from a more or less provincial type to one of seminar quality. Recognized medical teachers from teaching centers were invited to speak to the group. This provided easy learning—but it replaced something of value. No longer did the members of the society exercise and develop skills in preparing and presenting scientific papers. No longer was there in evidence a competitive spirit or an attempt to excel among one's local colleagues. As a result very few papers, either good, bad or indifferent have been prepared by members of the society during this era. There has been little incentive to prepare and little opportunity to present even a case report.

The difference between the old and the new practice here is similar to the difference in the culture of ancient Greece and that of ancient Rome. In Greece, culture, literature, and art was practiced by the citizens. In Rome, it was practiced by slaves and observed by the citizens. Which was the better?

This complete substitution of lectures by learned teachers for locally prepared papers was not intentional. It was planned that each program would include both types of discussions. The Columbia Society has wisely and successfully combined the two. One may speculate on the reasons for successful combination of the two types of program in the one case and its failure in the other.

The Bulletin was begun in 1938. It has been continued successfully, although its character has changed greatly. It no longer regularly deals with local or statewide medical problems. It no longer attempts to mold medical opinion or to initiate or stimulate corporate action. Perhaps, the change may be just as well. It parallels changes which have come about in the editorial policies of many great militant newspapers of an earlier day.

There has come about an important change in the medical libraries during the modern era. The society had a reading room for a time beginning in 1913. At the beginning, seventeen journals were subscribed for. There were gifts of some few textbooks. These were usually too new to have antique value and too old to be scientifically useful.

In 1942, when Greenville General Hospital became accredited for intern training, a hospital library was begun in a small way. Each year several new texts were purchased and several journals were subscribed for.

The Greenville Medical Club was a depository for old books from the libraries of recently or earlier deceased doctors of the county.

When the new hospital building was occupied, these three libraries were combined. A full time, efficient librarian was employed. The library remains open all night on an honor system. However, honor has not proved to be uniformly operative, and books and magazines are frequently lost. There are now about

two thousand fairly recent editions and about 105 journals in the library. The journals are permanently bound as the volumes are filled.

The Greenville Medical Foundation was organized in 1945. The purpose of this trust was, "To establish a fund, the proceeds of which shall be used solely for scientific, educational, and charitable purposes, including the promotion of the science of medicine, assisting medical students, the establishment of a medical library, and the construction of a building for such purpose or purposes."

The project was launched with great enthusiasm. It was believed that because of relatively high professional incomes and high income tax rates, tax free contributions to the foundation would be made readily and generously. However, results have been disappointing. Funds in hand at this time amount to somewhat less than \$25,000. Since they have been invested in government bonds, it is likely that interest accruals have not kept pace with the inflationary costs of building. Unless there shall develop a renewal of enthusiastic interest, that time when the society shall own its own home is far in the future.

The modern era in professional accomplishment in Greenville began with the arrival of Dr. David A. Wilson in 1946. His long period of training at Duke University Medical School and Hospital was concurrent with the tremendously rapid strides in medical scientific knowledge and application. He had grown up as it were with the new advances in surgery, made possible by advances in the knowledge of anesthesiology, physiology, pharmacology and body chemistry.

Prior to his coming, few if any of the doctors of Greenville were prepared to avail themselves immediately of the new knowledge and new techniques. Nor were the hospitals equipped for the application of them.

Dave lived only ten years after coming to Greenville. However, he lived to see a revolutionary change in the hospitals and their staffs.

Relatively large numbers of young men, equally as well trained as he, had moved in. The hospitals had prepared themselves to be efficient workshops for the execution of the newer techniques. Every surgical specialty and most of the medical subspecialties had become

represented on the hospital staffs. Two neurosurgeons were overloaded with work, orthopedic surgeons were working in groups of two or three. So were the obstetricians and gynecologists. Thoracic, heart and vascular surgery was more or less commonplace. Internists were now hospitalizing their patients for diagnostic studies instead of working in their private clinics. They were thus able to have the assistance of the pathologist and clinical pathologist, the roentgenologists and other consultants.

Another aspect of the new era is the improved economic status of the profession. Fees have advanced, but not excessively, nor so much as have living costs. The improvement reflects the improvement in the economic conditions of the people, and particularly the impact of sickness insurance on the ability of the people to pay sickness costs.

However, there are clouds on the medical horizon. Many thoughtful doctors sense a danger in the economic opulence of doctors. They fear that there will result a loss of the sense of dedication to service regardless of the sacrifice involved and a softening up of the discipline of medical practice. There is also a fear that the ever increasing costs of medical care, due in part at least to the diagnostic and prophylactic phases of medical practice, will result in unhappy changes. Under the guise of "thoroughness," or of "treating the body instead of the disease," or of "good medical practice," indications for hospital admissions, for expensive x-ray, and for other laboratory examinations have been tremendously broadened. The frequent sketchy justification for expensive laboratory procedures, with corresponding high percentage of negative findings, seems to many students of the increasing costs of medical care to have made of the demand for "good medical care of the whole man" an unwise and unwarranted absurdity.

This uncritical attitude, with its ever increasing demands for more hospital beds, its constantly increasing costs, and its increasing demands for broader and broader insurance coverage, may well be the determining factor in ushering in the next historical era of medical practice. If and when it does, that era, called by whatever name you will, will be

one of governmental regulated and administered socialized medicine.

The days of which I have written were the days of medical giants. Those days seem to have gone forever. There are and always will be great medical scientists and technicians. They will not stand out on the stage of medical history as did John B. Murphy, John B. Deaver, DeLee, Clark, the Mayo brothers, Osler, DaCosta and others that any early twentieth century doctor could name. Those men were giants not alone because of the quality of their intellect and their skill. They were showmen as well.

Those men were giants on the national stage. There were smaller stages, like that in Greenville. The men of whom I have written were giants on this smaller stage, but they were giants withal. Professor A. M. Schles-

inger, Jr. recently, in writing of great men in statesmanship, said: "Our age is an age without heroes—and when we say this, we suddenly realize how spectacularly the world has changed in a generation. Most of us grew up in a time of towering personalities."

This could also be said of medicine. In our time, the average of medical ability and training is much higher than it formerly was. The number of actors is greater. It is difficult for one man to stand out as a giant above his colleagues. The title of a laboratory scene in a Monsanto Chemical Company film states: "No geniuses here, just a bunch of average Americans working together." So it is with American or South Carolina or Greenville County medicine. We are carefully selected, well trained doctors, all working together happily in our chosen work under the banner of Aesculapius.

MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

Angina in mitral stenosis

DALE GROOM, M. D.
Dept. of Medicine

Case Record—With one exception, the history of this 40 year old housewife's illness was classical for rheumatic mitral stenosis. It was a sequence of recurrent rheumatic fever with migratory arthritis, epistaxis and chorea in the second decade of her life, followed in the third by dyspnea, orthopnea, dependent edema and, ultimately ascites, emaciation and hemoptysis. She had managed to go through two normal pregnancies by age 20, though with mounting difficulty necessitating a tubal ligation for cardiac reasons. Survival beyond age 35 had been largely a matter of rigorous measures for control of congestive failure.

An unusual symptom which appeared late in her illness was angina pectoris. In spite of a decline in her weight to less than 100 pounds and the extreme limitation of her exercise tolerance by dyspnea, she had experienced substernal pain with radiation down both arms, of mounting severity during the previous year. This pain was invariably precipitated by even slight exertion and frequently it awakened her at

night. Characteristically the pain was relieved promptly by rest or by nitroglycerin which she took daily and there was no history of prolonged chest pain suggestive of infarction.

Auscultatory examination disclosed murmurs of aortic stenosis and early aortic insufficiency, as well as mitral stenosis (a long rumbling diastolic murmur at the mitral area with presystolic accentuation, heard best with the patient lying on her left side), and a mitral systolic murmur of moderate intensity. The mitral first sound was accentuated but most striking was a very loud second heart sound at the pulmonary area, denoting a high pressure in the pulmonary artery. A forceful thrust could be felt over the mid-precordium on systole. The patient's blood pressure was 112/72 and there was no discernible pulsation in the retinal arterioles.

Cardiac fluoroscopy and films showed selective enlargement of the right ventricle, the left atrium and the pulmonary artery. Vascularity of the lung fields was increased and the "Beta lines of Kerley" (indicative of increased pressure in the pulmonary veins) were present near the costophrenic angles. The indentation of the barium-filled esophagus by the left atrium was observed to be of the high, short, "cup-like" configuration seen commonly in mitral stenosis, as contrasted to the long, sweeping configuration

ascribed to mitral insufficiency. No hypertrophy of the left ventricle nor any intra-cardiac calcification was demonstrable.

Because mitral stenosis was believed to be the major limiting factor in this case, a mitral valvulotomy was performed. The valve orifice, estimated by palpation to be no more than 2 x 8 mm., was successfully opened by manual dilatation. Following this there was a marked decrease in palpable tension in the pulmonary artery which was greatly enlarged. A minimal regurgitant jet through the mitral valve was noted before and after dilatation, and a systolic thrill could be felt over the aortic valve.

The patient's postoperative course was uneventful except for transient atrial arrhythmias. When discharged from the hospital two weeks after surgery her rhythm was regular and the angina pectoris had not recurred. Two months later she was reported to have remained free of both congestive failure and angina, to be gaining weight and resuming physical activity.

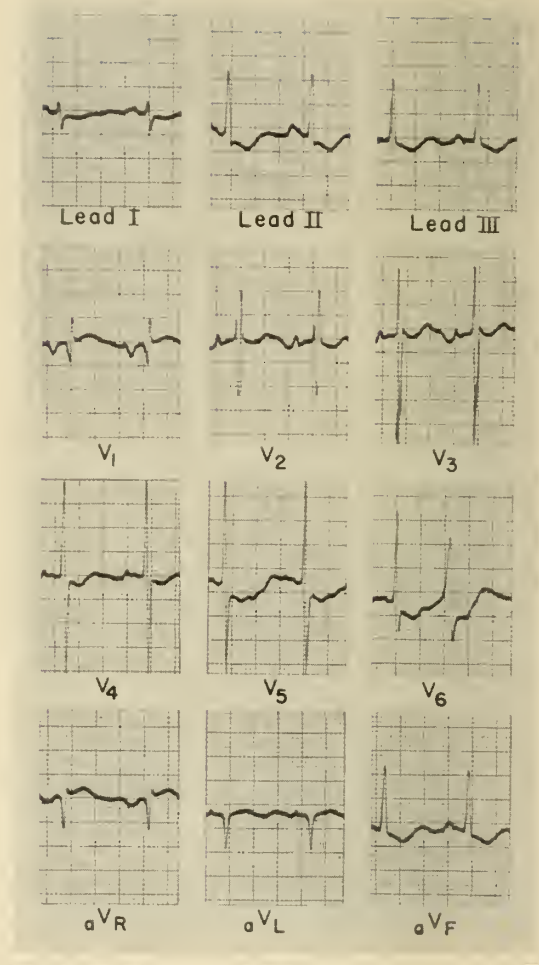
The electrocardiogram illustrated is one made preoperatively with the patient at rest.

Electrocardiogram—The rhythm is a regular sinus one at a rate of 88 with a normal P-R, QRS and Q-T intervals. A ventricular ectopic beat is seen in V_6 and these were frequent in the complete tracing. The P waves, while not grossly abnormal, are unusually prominent in several leads. Axis of the QRS complexes is vertical, with the deflections almost entirely negative in leads from above (aVR and aVL) and positive in aVF below.

Late R and R' waves in the right precordial leads denote delayed activation of a portion of underlying ventricular muscle, presumably of the right ventricle, consistent with hypertrophy. Apparently there is no appreciable left ventricular hypertrophy for the intrinsicoid deflection of the R wave of the normally conducted beat of V_6 is not delayed. Polarity of the T waves is reversed in most leads (upright in V_1 and AVR, diphasic or inverted in most others) and some of the inversions resemble those of digitalis effect. U waves are conspicuous throughout.

The degree of displacement of S-T segments—more than 2 mm. depression in V_5 and V_6 , with some reciprocal elevation in the right sided leads aVR and V_1 —is greater than one might expect from digitalis alone and decreased to less than 1 mm. in the postoperative electrocardiograms.

Discussion—Had it not been for the electrocardiographic and roentgenographic evidence of right ventricular predominance with little or no hypertrophy of the left ventricle, this patient could not have been seriously considered for mitral valvulotomy. Her rheumatic heart disease was known to involve both aortic and mitral valves, each with some degree of stenosis and insufficiency. All except the mitral stenosis would be conducive to left ventricular hypertrophy. Additional deterrents to surgery were the advanced congestive failure, the cachexia and the anginal syndrome of uncertain significance. The fact



that the left ventricle was not appreciably enlarged nor the pulse pressure altered indicated the limiting factor in this patient's case to be the mitral stenosis, an assumption borne out by the evidences of increased pressure in the left atrium, the entire pulmonary circulation and the right ventricle. Fortunately the lesion most amenable to surgery was the weakest link in the chain, the stenotic obstruction at the mitral valve.

Angina pectoris has been variously estimated to occur in 8-10% of cases of mitral stenosis. Its mechanism is obscure but perhaps the most plausible theory is that it arises from compression of the left coronary artery between the enlarging left atrium and pulmonary artery. Were the angina due to a concomitant lesion of the aortic valve it would not likely disappear following mitral commissurotomy, and if due to coronary atherosclerosis it might actually be made worse by restoration of normal filling and work load of the left ventricle. A possibly analogous situation is the occasional association of hoarseness or aphonia with mitral stenosis, ascribed to compression of the left recurrent laryngeal nerve against the aorta by a distended pulmonary artery. Certainly the S-T abnormal-

ities in this tracing are consistent with coronary insufficiency which seemingly was reversible.

Acknowledgement: I am indebted to Drs. L. E. Davison and Jim Adams for follow-up reports on this patient's postoperative course.

Pathological Conference

J. R. PAUL, M. D. — H. R. PRATT-THOMAS, M. D.

Present Illness: This was the first admission of a 3½ year old colored girl to the Medical College Hospital on May 25, 1959. Onset of present illness began three days prior to admission with elevated temperature followed by weakness of the right lower extremity on the same day. Seen by a physician the following day and found to have paralysis involving both lower extremities. She was hospitalized on the next day at Beaufort. Spinal fluid examination showed globulin 2+, 132 WBC (127 lymphs); 165 RBC. White count was 9,500, Hgb 12.4 grams, normal differential. During hospitalization at Beaufort developed ascending paralysis and generalized weakness. Therapy consisted of Combiotic 1 ml. q 12 h. Child has had persistent abdominal distention since admission to that hospital.

Past history revealed full term spontaneous delivery by midwife at home; birth weight not recorded. In good health up until present illness. No immunizations, no allergies.

Family history was non-contributory.

Physical examination showed a poorly developed, poorly nourished colored girl lying flat and unable to sit. Flaccid paralysis of lower extremities; able to move upper extremities slightly. Unable to raise or support head. The head was negative and the chest symmetrical. Occasional rales were heard in both lower lobes. The abdomen was slightly distended; no organs or masses palpated. No cardiac murmurs. Blood pressure 110/60 mm. Hg. There was flaccid paralysis of lower extremities with marked weakness of upper extremities. Superficial reflexes were absent as well as patella and achilles reflexes. Biceps and triceps 1+. Marked head lag and unable to support body. No sensory deficiencies could be detected.

Course in Hospital: Gradual progression of ascending paralysis. Periodic fluoroscopy chest showed increasing weakness of leaves of diaphragm and on May 29 the patient appeared more toxic. Pneumonitis thought to be setting in and tracheostomy performed. Placed in respirator. On May 31 rales left chest heard; started on erythromycin. Short time later patient suddenly cyanotic; spontaneous respirations ceased, pupils widely dilated. Pronounced dead that afternoon.

Laboratory Work: Urinalysis normal. CBC May 25 Hgb. 14.5 gms., RBC 5.3, WBC 8,700 Polys 56 (1 non-fil), lymphs 35, mono. 5, eos. 4. Sick cell preparation neg. VPC 47. Spinal Fluid: Opening pressure 110 cloudy, xanth. +, WBC 154 (polys 37, lymphs 62) erythrocytes 537 (98% cren); Sugar: 55 mg/100 ml. Cl. 720 mg. Total protein 45 mg. Spinal fluid smear & culture negative for acid fast bacilli.

Throat culture: negative. ECG: Lt. axis, otherwise normal. Tuberculin (PPD) negative. Feces negative for virus.

Dr. Paul (conducting): Mr. Johnson, please give us your analysis of this case.

Student Charles Johnson: This is a fulminant case of about nine days duration whose chief clinical manifestation was that of increasing paralysis. My working diagnosis is poliomyelitis. The spinal fluid findings of increased protein with 154 cells showing a preponderance of lymphocytes is consistent with this diagnosis. The most important disease which must be differentiated is Guillain-Barre' disease or Landry's paralysis. The protein-cell disassociation in the cerebrospinal fluid is the most important laboratory finding in Guillain-Barre disease and is not present in this case. This disassociation also occurs in post-diphtheritic polyneuritis and certain metabolic neuropathies, but as we do not have this finding nor any history to support these other diagnoses they may be dismissed. The lower motor neuron lesion with flaccid paralysis is fitting to poliomyelitis, except that the speed, symmetry of involvement and rapid ascension of the paralysis is not characteristic of poliomyelitis. The absence of any sort of infection prior to the present illness and the presence of fever are more in favor of poliomyelitis than Guillain-Barre disease. The total lack of any sort of paresthesia militates strongly against Guillain-Barre and is much more characteristic of polio. I found the blood in the spinal fluid bothersome and considered hematomyelia. There is no history of trauma and the paralysis was an ascending one, so that I was forced to conclude that the blood indicated a traumatic tap and was of no significance.

Dr. Paul: Mr. John Dunlap, do you agree with this discussion or have any other suggestions?

Student Dunlap: I am in agreement that this is most likely poliomyelitis. Heavy metal poisoning by a substance such as lead might be considered, but I doubt that it would be this devastating in course and outcome. I am sure the child was carefully searched for a tick as tick paralysis could follow this course, but the spinal fluid would be normal. Porphyria can produce severe neurologic disorders, but there is no story of abdominal pain, light sensitivity or skin eruption. I would say that this is most likely poliomyelitis.

Dr. Paul: Can anyone give the reason for doing a tracheostomy on this child?

Student Arthur Hutson: It was done to prevent the aspiration of oral and pharyngeal secretions in a patient who might not be swallowing properly. This might be a particular hazard when subjected to the negative pressure of the respirator. Furthermore this patient has diaphragmatic and thoracic cage paralysis and the bronchial secretions will accumulate and produce atelectasis unless they can be systematically aspirated without resorting to intubation on every occasion.

A student: It seems to me that this child's blood pressure is elevated and that this might be a response

to hypoxia produced by extension of the disease to the bulbar centers.

Dr. Paul: The diagnosis of poliomyelitis may be difficult to make, particularly if a given case does not occur in an epidemic setting. Milder cases and non-paralytic ones, may of course be even more of a diagnostic problem. This case was very severe and, if this is poliomyelitis, we were misled by the rapidly progressive symmetrical paralysis. We thought that the case represented infectious neuronitis or Guillain-Barre disease.

Dr. Pratt-Thomas: Diagnosis: Acute poliomyelitis of spinal cord and bulbar region.

Although this disease was clearly recognized during the latter part of the eighteenth century the first good description was made in 1840 and the first account of an epidemic of any magnitude was recorded in 1891. It is believed that the disease is an ancient one, but its pattern of occurrence has changed during the 19th and 20th centuries so that it has been transformed from an endemic to epidemic disease. The age incidence has also changed so that it now more commonly affects children about five years older than those formerly attacked. The term "infantile paralysis" is losing its significance not only because of this shift to older children, but also because many adults are now its victims. The disease is spread by human contact but the exact mechanism of its transmission are controversial. It is hoped that it has now begun its decline and joined such respected human

adversaries as syphilis, bacterial infections, malaria and tuberculosis in their march toward oblivion. The pathologist is more fortunate than the clinician in that he is able to make a definite diagnosis without difficulty. This may be done in spite of the fact that there are no inclusions which are pathognomonic of the disease.

Grossly there are no characteristic lesions of poliomyelitis and microscopically there are no distinctive lesions outside the central nervous system. In this case the only gross abnormality that could be found were areas of atelectasis, most marked in the right lung. Nothing could be seen in the brain or spinal cord. Microscopically, however, it shows the hallmark of all viral disease of the central nervous system, namely, prominent lymphocytic vascular cuffing. There is extensive destruction of the neurones of the anterior horns with conspicuous macrophagic or gitter cell response. This neuronal damage extends up into the medulla, pons and roof of the fourth ventricle. The virus does not react with myelin, neuroglia or vessels. It affects only neurones. The anatomic distributions of the lesions, and their relation to neuronal destruction provides a picture that is found in poliomyelitis alone. It involves only certain pontine and medullary nuclei. The cerebellar hemispheres and the cerebral cortex except for the motor and premotor areas are spared as are the optic nerve and any of the other association areas of the cortex. This case then on the basis of neuronal destruction and anatomic distribution of the lesions is unequivocally poliomyelitis.

Isocarboxazide: A new antidepressant drug. R. B. Ford, H. E. Branham and J. J. Cleckley. Clin. Med. 6:1559, Sept. 1959.

Isocarboxazide (Marplan)^(R) an analog of iproniazid (Marsilid)^(R) was found to be 6 to 30 times as potent an inhibitor of amine oxidase as iproniazid in various laboratory studies. This inhibition of amine oxidase is believed to be the chief mode of action of this group of antidepressant drugs.

This study included 28 patients with various forms

of depression commonly seen in a general office practice. The patients were followed for 3 to 6 months and an excellent result was obtained in 13 patients and a good result in 12 patients. In the other 3 patients there was either slight or no improvement. The starting dosage was 20 mgs. to 30 mgs. with reduction to 10 mgs. or 20 mgs. as soon as improvement was noted. The only significant side effect was moderate relative hypotension in 4 patients which did not necessitate withdrawal of the drug.

PRESIDENT'S PAGE

The beauty and the strength of a lasting edifice depends upon the quality of the material with which it is built. The presence of a defective block in the structure of a building mars its beauty and undermines its durability. Similarly, a strong, serviceable State Medical Association is dependent upon the interest and integrity of its components—the County Medical Societies. The South Carolina Medical Association must not look to the American Medical Association to do its thinking. Similarly, the physicians whose county societies make up the South Carolina Medical Association, should not look to the State Association to tell them what to do. Actually, it has to be the other way around.

The local County Society is the most important unit in the South Carolina Medical Association. It is only at this level that problems which affect the individual physician in his particular locality can be met with and discussed. If these problems can not be solved on the local level, they can be carried to the State Association where they will receive the benefit of the thinking of all the counties and, similarly, on to the American Medical Association if necessary.

Often we have heard the question "Why does the American Medical Association take such and such a stand, or why does the South Carolina Medical Association say so and so?" The answer, of course, is that the American Medical Association as such, does not take any stand. It is the majority vote of the delegates from the individual State Associations making up the American Medical Association, which determines its policy. Similarly, the South Carolina Medical Association takes no stand. The policies of the South Carolina Medical Association are those which are arrived at by majority vote of the delegates from the individual county societies.

The County Society is all powerful. No physician can belong to the South Carolina Medical Association, or the American Medical Association, without first having been elected a member of his local county society. The reason for this is clear — the local county society is in a better position to know and to judge the qualifications of a man who seeks membership in our medical organizations than any other party. Similarly, discipline must be taken on a local level. The South Carolina Medical Association has no right to expell a member unless that recommendation comes from the local county society. It is true that the South Carolina Association has set up a mediation committee where complaints might be aired through an impartial board if the local society so desires. However, many local societies have their own mediation committees. The ethics of the profession, the public relations of all doctors in the State depend on how these things are handled at home.

In the past few years the South Carolina Association has had occasion to call on the county units for help in the resolution of problems which have developed on a statewide basis. The fact that we have been successful in these efforts is proof of the power which lies in the county societies. Without the support of the individual county delegations, which support is directly in response to appeals by these local county societies, the problems which we have faced in the State Legislature would have been much more trying and in many cases we would not have succeeded.

In taking over the job as President of the South Carolina Medical Association, I am deeply cognizant of the honor which has been bestowed upon me. No one realizes more than I do that I was not elected by a State organization as such, but by the membership itself—representing each county in the State.

My purpose for the coming year is to be one of full cooperation with the county societies. My aim during the coming year will be to meet with each individual society during that time. When regular meetings are not convenient, it will be my endeavor to meet with the groups in informal breakfast, or luncheon gatherings as seems most suitable for a particular area. At these meetings I would hope that a full discussion of medical questions could be carried out and all questions answered and clarified. Clarification of ideas means that stronger programs will develop. Many subjects come to mind about which there are always areas for discussion.

- Among them are:
- (1) On Public Relations Program.
 - (2) Civil Defense.
 - (3) State Legislation concerning Osteopaths, Optometry Blood Banks, etc.
 - (4) Blue Cross and Blue Shield.
 - (5) Health Legislation for the Aged.
 - (6) The Benevolent Aid Society for Indigent Physicians and their families.
 - (7) Medicare.
 - (8) The State Insurance Program.
 - (9) Permanent home for the Association.

And many others.

It is my desire to have each county in the state fully informed on all matters which pertain to the State Association as a whole, and I want to be fully informed on all of the problems which involve the local counties. In this way we can be of real service to each other.

In closing, I would like for you to remember: In so far as medical affairs are concerned, your local County Medical Meeting is the most important meeting that you can attend.

Joseph P. Cain, M. D.

Editorials

CONCERN FOR THE AGED

The last of a series of regional conferences on aging sponsored by the A. M. A. was held in Baltimore March 30-31, 1960. Previous to that time an areal conference comprising the states of Alabama, Florida, Georgia, North Carolina, Tennessee, and South Carolina was held in Atlanta March 7-8 and was attended by a number of representatives from South Carolina and from the South Carolina Medical Association particularly. While the program was inclusive of various "disciplines" and somewhat replete with "challenges", it offered an excellent survey of the situation of aged people and of current efforts to make their situation comfortable and secure. There was no exposition of the need for governmental provision; indeed the dirty word "Forand" was mentioned only once and casually dismissed.

It was said that the problems of the aged are essentially the same in quality but tremendously multiplied in quantity. One speaker thought that we had built a false image of old age; that we need new attitudes and new opportunities to afford the quality of dignity and the privilege of participation to old people. There was a general frown of disfavor upon mandatory retirement at a fixed age. Local concern, not federal care, was emphasized as desirable and the only practical approach. The obligation of the churches and the educational system was mentioned. Dependence on federal provision would destroy family and community responsibility and initiative.

There was much discussion of the available means for improving the lot of the aged, such as home care programs, rehabilitation, nursing homes, home making services, shortening of hospital stay. Favorable reports were made on actual applications for these services in many places, and it was believed that they would become more and more extensive as more concern develops for the problem.

Correlation of the numerous groups inter-

ested in the problem of the aged was considered to be essential. Organized medicine represents only one element. State programs are active in many places, for example, in South Carolina. The Committee on the Aged of the South Carolina Medical Association participates in the activity of a Joint Committee of various interested organizations, now headed by Dr. William Cochran of Spartanburg, and works with the Governor's Committee through the activities of the Joint Committee.

It was noted that age and poverty were not synonymous; that the later years often afforded the best bracket for possession of liquid assets. With years added to life it is essential to add life to these years—occupation, education, dignity, responsibility, recreation, hobbies—all of which should be planned in advance. The great growth of prepayment plans of health insurance promises tremendous help to the group.

The tone of the conference was distinctly optimistic and the feeling appeared to be profound that the provision for the aged was a local do-it-yourself job, not a matter to be botched paternalistically and bureaucratically.

THE MEDICAL CAINS

The South Carolina Medical Association seems to pick presidents with well established medical backgrounds. This phenomenon has been noted here before. Now again we find that Dr. Joseph P. Cain our new chief officer has come honestly by his choice of occupation and his distinction in his profession.

Dr. Cain's grandfather, Dr. Joseph Palmer Cain, was born in St. John's Berkeley and graduated at the Medical College in Charleston. At the outbreak of the Civil War, he volunteered and entered the 10th Regiment. Desiring more active service, he resigned from his post and served as a volunteer aide on the staff of General A. M. Manigault through the bloody campaigns of the Army of Tennessee. Later he reentered the Army as a surgeon, was

captured in Virginia, imprisoned on a ship, exchanged, and returned to the Army. After the War he practiced medicine in St. John's Parish until his death in 1903.

Dr. D. J. C. Cain was another prominent member of the family. He was a teacher, writer, editor, and practitioner, carrying out the first function in the Charleston Preparatory Medical School and the Medical College of the State of South Carolina. He contributed frequently to the *Southern Journal of Medicine and Pharmacy*, published in Charleston, and in 1850 became editor along with Dr. S. P. Porcher. He wrote for the *Transactions* of the A. M. A. (he was a delegate in 1850) and was active in the organization and progress of the South Carolina Medical Association. With Dr. J. J. Chisolm he conducted a hospital for negroes at 4-6 Wilson Street in Charleston. He spent his latter years in Asheville, North Carolina.

Dr. Joseph Cain is a nephew of Dr. Francis G. Cain, well known surgeon of Charleston, two of whose sons, Dr. James Cain and Dr. William Cain are Doctors of Medicine.

The medical tradition seems to be attached to the genes of the Cain family.

major developments and unexpected changes which may have modified an old picture considerably. The Kennedy proposal which has been somewhat overshadowed by the Forand Bill is still to be heard from, and in its original form it was even more inclusive and more objectionable than the Bill which has just been put to sleep. Other legislation similar to the Kennedy proposal has been already advocated, and no doubt since the Forand effort has not been successful there will be other approaches to accomplishing the same objectives. The Administration Bill which Secretary Flemming has announced he has in preparation is said to be of a different type, not corresponding to the propositions urged by Forand. How far this one will go is still a question, as there has been little indication of exactly what is in the mind of Mr. Flemming.

The crystal ball is not very clear as to what the situation will be by mid-May when this appears in print. Whatever it may be, it will probably require considerable effort and constant vigilance on the part of the profession to forestall any objectionable type of legislation, such as most of the likely proposals will be.

THE AMA TO MEET

WASHINGTON DID NOT SLEEP HERE

At the time of this writing, the Forand Bill seems to be probably a temporarily comatose issue. Having been voted down by Committee, it is not likely to be able to muster the large number of signatures from the House members which would be required for a consideration by Congress. Whether the effort which was made by members of the medical profession and their various organizations was responsible for the temporary blocking of the Bill is not clear, but certainly the effort was worthwhile and the pressure on Congressmen must have been considerable—strong enough to counteract that which had been applied by labor and other organizations for the passage of the Bill.

It is quite possible that by the time this editorial is published there may have been

There is probably nothing in the world like the Annual Meetings of the American Medical Association in size, content, and in accomplishment. The time has come around now for the 1960 meeting which will be held in Miami Beach, Florida, June 13-17.

The Association is of the opinion that the location is ideal for the doctor and his whole family and certainly the scientific program offers an outstanding postgraduate opportunity. There is something for everybody, and the range is wide.

In this issue of *The Journal* there are several advertising announcements concerning the meeting. They indicate only a few of the choice presentations which will be available.

Attendance at one of these meetings is an experience valuable to everybody and one which will not soon be forgotten.

TALK TO THE ANNUAL CONFERENCE
OF SOUTH CAROLINA COUNTY
MEDICAL SOCIETY
PRESIDENTS AND SECRETARIES

JERE W. ANNIS, M. D.

Lakeland, Fla.

Columbia, South Carolina

February 28, 1960

It is certainly a pleasure to be with you today. Such meetings as this have been invaluable to us in Florida, and we propose to continue them, as I trust you do. It is because I believe so sincerely in their effectiveness that I was happy to accept Jack Meadors' kind invitation to come up here today and speak with you, briefly, about the responsibilities of County Medical Society Officers. I am indebted to you for your invitation and your hospitality.

I will ask you to please remember that the sentiments expressed by me, and the suggestions made, are based entirely upon the situation as I know it in Florida. Much of this may not be applicable to you in South Carolina, but I have the feeling that there is, to a large extent, a common denominator for our problems. The fact that you are gathered together here today is, in itself, evidence that you are cognizant of the fact that there is still much work to be done in the field of improving communications and performance amongst the medical profession, and in strengthening professional and public relationships. This, I believe, is an excellent way to accomplish your goal. Certainly the interchange of ideas at such a meeting and the explanation of the *modus operandi* of the State organization and its relationship to the County groups cannot help being of real benefit to you as Officers of the County Societies.

Our Medical Association—and I am sure, yours—is getting to be a good-sized business. We handle considerable sums of money. We own real estate and equipment. We have investments—and we are constantly engaged in state-wide and national business of considerable importance. Hence, the means of communication between those individuals charged with conducting this business and the remainder of the physicians in the state, is becoming more and more important. I am sure that this meeting will make your job as an officer of your County Medical Association easier.

And now, let me return to my subject—the responsibilities of a County Medical Society officer. As a past president and secretary of a County Society, I, of course, feel eminently qualified to do this! Like all ex-officers, I am able, with the utmost ease, to gaze back at my own tenures of office, conveniently fading out all the disastrous, embarrassing and ill-conceived moments—and focusing sharply on only those few minor successes that occurred coincidentally with my terms. This is the prerogative of an "Ex"—just as it is his somewhat boring obligation to give to his successor advice which he himself failed to follow, and

to answer problems which he failed to recognize. I am no different from the rest. Yet, the responsibility of the County Medical Society is a problem in which my interest continues. And so we can perhaps discuss it together, since it is my problem—and yours—and indeed that of every physician in organized medicine.

You, gentlemen, are the acknowledged leaders of medicine in your communities. You stand in the position of being able to influence the future course of our profession—more than anyone else. Upon your shoulders rests the responsibility for the proper execution and direction of the strategy through which this team of South Carolina physicians can cooperatively perform its best and most effective efforts for mankind within the public arena. Certainly it is the responsibility of the individual County Medical Society to make certain that its members attain and sustain—the highest possible professional standards—the highest medical ethics. This is one of the foremost and traditional of our avowed purposes. It is one which our members accept almost universally, and one in which they wholeheartedly cooperate. It is self-evident.

But your County Society has an additional—and a no less important duty—in its responsibility to promote active coordination and leadership in all the health activities of your community—to see to it that capable and articulate representatives of the medical profession are on the boards—the committees—the councils—which initiate, direct or control any community activity relating to health. Your city—your county—has a right to expect this highly-specialized advice and leadership from you. It is your duty not only to provide it upon request, but to unselfishly proffer it in anticipation of such a request.

Furthermore, you have, it seems to me, the responsibility of instilling into your individual members their too-often-forgotten responsibility as citizens and as members of the non-medical community. You have the responsibility of encouraging your physicians to take an active part in local, state and national political problems, to raise their voices in protest at ineffective or dishonest administration, and to share freely with their neighbors their information—their thoughts—and their philosophy on current community problems. You have the obligation, in short, to remind them frequently and convincingly that they are citizens as well as physicians—and you have the responsibility, too, of erasing the often unpleasant stigmas that cling to members of our profession who honestly and sincerely offer to share their talents, their time, and their convictions in positions or on issues of public interest. You have the responsibility of reminding your colleagues that they have a right, and indeed an obligation, to be interested in and informed upon current political issues, and that intellectual isolation in our professional life is neither admirable, nor courageous. It is *your* job to remind *us* that we are members of a community—of a State—and of a Nation—as well as of a great profession; and it is your job to help make us the unselfish, dedicated, ethical and intel-

ligent individuals that we smugly believe ourselves to be. To do this, and to keep the respect—the friendship—and at times even the speaking acquaintance of your colleagues, is something of a task.

Then, beyond all this, beyond the responsibility for improving the basic product, if you will, you have the additional responsibility of providing a positive and constructive program that will ensure the advancement of our profession, scientifically, socially and civically within the community. You have the responsibility of developing a public relations program that will sell this product, in its most desirable light, to the men and women with whom you are in daily contact. This public relations program is an important charge involving an unending bilateral struggle to ensure proper performance by the individual members of your Society, and proper understanding and appreciation of this effort by the community at large.

It is your duty to weld the individual physicians in your community into a strong, cohesive, highly-ethical professional unit, which not only performs daily its dedicated services to humanity, but which also takes an active and forcefully directive part in the extramedical problems which confront us all as citizens in this ever-changing world.

It is your duty to keep this unit favorably represented to the public in whose midst it exists, by making known its many virtues and its dedicated service; and it is further your duty to keep this unit apprised of the thinking, the decisions, the policies, the programs and plans of the parent organization, the South Carolina Medical Association, and of the national confederacy of which it is a part, the American Medical Association. In this way, your members may intelligently study the problems, and help to compound the answers, which will establish state and national policies that will direct our course through the troubled seas ahead.

Finally, it is your duty to keep yourself informed upon your Blue Shield organization, and to make your constituents in your County Society fully aware that this is *their plan*. It is essential that you, as the leaders, and they as the members, of the medical profession in this State, be fully conversant with the Blue Shield policies which are being offered throughout South Carolina. If these policies are not adequate and effective; if they are not competitive and acceptable, then you, the directors of the Medical Service Plan, should make them so. Yours is the responsibility to be intelligently and comprehensively informed, not only upon the problem which faces the low income patient, but of the solution which you collectively have offered through your Blue Shield plans.

This organization is truly your shield against many of the diverse ills which beset the Medical Profession. It behooves you to keep that shield strong, bright, shining, and to know how to use it. This, too, comes within the province of your responsibilities.

The importance of all this—and the dire results which will surely ensue if you fail to live up to these—your duties and your obligations—were im-

pressed upon me most seriously as I traveled about our State last year. The apathy which I found, and the indifference which I encountered, as well as the laxness of civic, moral and ethical standards which were too often evident, were responsible for the fact that I requested our House of Delegates to remain in Executive Session at the end of our annual meeting last May, in order that I might try to communicate to them my deep feelings on this subject. What I said then came as a culmination of recent events and recent experiences. To me, at that time, it was burning, vital and all-important. Since it is always difficult to successfully recapture a mood and adequately rephrase one's convictions at a remote and perhaps less emotional date, I should like to take the liberty of concluding this talk with a recording of those very brief remarks made last May at The Americana Hotel, in Miami Beach, at the conclusion of our annual session. After this I have done.

March 19, 1960

REPORT TO THE PRESIDENT OF THE SOUTH CAROLINA MEDICAL ASSOCIATION concerning the writer's attendance at Brooks Army Medical Center, Ft. Sam Houston, San Antonio, Texas, February 15th through 19th, 1960.

"MANAGEMENT OF MASS CASUALTIES COURSE": As a member of the South Carolina Medical Association group on State Civil Defense, I was asked by their president to attend the above course on the management of mass casualties. This identical course is put on by the Brooks Army Medical Center, Ft. Sam Houston, San Antonio, Texas and is scheduled every other month throughout the year. The course attended by the writer was February 15-19th inclusive, and was the sixth session instituted by the Medical Center.

In attendance there were 128 men and women, either physicians representing the medical aspect or nurses representing the nurses interest or hospital personnel representing the Disaster Committees of various hospitals or Civil Defense directors representing the combined and unified Civil Defense plan for various states. These representatives were literally from all over the country, including a representative from Alaska, one from Puerto Rico and others from nearly every state in the union. The great majority of those in attendance were Army, Navy, Air Corps, and Marine reservists who had some comparable Civil Defense job with their various state organizations. Some represented kindred or related medical profession such as dentistry or veterinarians or members of the various disaster plans of large hospitals throughout the nation. In addition to these in regular attendance for the full five days, there was the complete junior and senior class from the Texas Medical School in attendance for the final day which consisted of a full day of practical demonstrations of what had been taught the previous four days. This last day, called "Operation Blow Up", was truly the cream of the entire course and without exception we all were

amazed at the Army's ability to put on a demonstration of this magnitude which was so clearly viewed and which dealt with every phase of the previous four days subject matter—this day, alone, was well worth the time, effort and expense of every concerned and farthinking doctor in South Carolina to attend. It is my understanding that a real effort will be made to have the junior and senior classes of all Medical Schools in the nation to attend this day at one of the future courses.

All of us arrived at Ft. Sam Houston on February 14th and were assigned regular army quarters. We used the regular army dining facilities and were given cards allowing us to use the facilities of the PX, Officers' Club, etc. throughout Brooks Army Medical Center and Ft. Sam Houston.

The following morning sharply at 7:30 there was a complete assembly, a short welcoming address by Major General Wm. E. Shambora, Medical Corps Commanding General, followed by a quick outline of what was to follow given by the officer in charge of the program, Col. Frank A. Neuman, Chief of Nuclear Warfare and Casualty Studies. And then classes began in full earnestness. Our classes consisted of various illustrated lectures given by the teaching personnel of Brooks Army Medical Center but included explanatory and illustrated lectures by the Corps of Engineers, Artillery, Infantry, Armored Divisions, Chemical and Biological Warfare and the Veterinary Service.

The planning and execution of these courses as well as the final demonstration day was designed to bring up-to-date the Medical Corps' concept of handling mass casualties, both with and without the advent of nuclear warfare. In order to do this it was necessary that civilians such as myself have some smattering of the tactical situation that would be necessarily dealt with by the foot soldiers, both offensively and defensively that would result in the mass casualties to be treated and handled by the Medical Corps. We were then given the concept of treatment in the normal warfare and then the concept of its immediate change-over to a method of handling a much different type of casualty and tremendously expanded number of casualties resulting from nuclear warfare. The civilian medical and paramedical groups are, of course, primarily interested through Civil Defense in the handling of mass casualties resulting from nuclear warfare.

Our final day of training was "Operation Blow-up". This was held at a training area about thirty miles away from Ft. Sam where we were all taken in busses and seated in bleachers overlooking a large section of the training area. At this point the commanding officer explained by maps and drawings exactly what we were to see in the distance and it was set up to simulate a small attacking force against a small enemy installation which called for the explosion of two very small sized nuclear bombs. The tactical situation also called for Maypom bombs delivered by jet air craft. Once this explanation had been completed the word

was given and "hell broke loose". It was amazing how clear the progress of the simulated warfare could be followed and the simulated atomic explosions were just as seen in the newsreel. The casualties could be seen being brought back by stretcher and jeep, then helicopters came in almost at ground level, picked them up and moved them back out of sight.

Once this operation was over the entire group was moved to another set of bleachers about four or five miles distant which represented a "sorting station" and in the meantime the "casualties" had also been brought back to this area. This station illustrated more than any other the massive amount of time and effort that the Army Medical Corps had gone to to make this program realistic. Here each casualty (and there were about 250 of them) was as realistic as you would expect to find on a battle field except for flowing blood. Each wound had been doctored up with clay and paints to represent the actual injury and these injuries ranged from thermonuclear burns that were represented by large bullae over the entire posterior surface of the body to one traumatic amputation that was as realistic as I have ever seen. Others had tree limbs apparently driven into the chest wall, one had a facial wound with an ear torn away that made you think that this fellow had gotten in there by mistake, that he really was hurt, and needed immediate attention.

The point, however, of this particular demonstration was to show just what the commanding officer did at this point. His job was to view the injuries and classify them according to severity of injury and prognosis—minor wounds requiring no medical aid other than self-care or "buddy-care" or emergency attention, those which required some emergency procedure necessary for lifesaving. The third classification was delayed treatment consisting of those who would require prolonged hospitalization and the last category was expectant, those cases that were apparently critically injured and not likely to survive. The casualties were to be moved in that order, one, two, three, and four as conveyance was available.

Next, we were transferred by bus again to the hospital areas where we again found the same casualties had arrived before us and had been separated into the various units corresponding to the type of treatment indicated. At this station it was just illustrated again which types of casualties were treated and the treatment facilities available for them.

From a Civil Defense point of view it was encouraging to hear the Army Medical Corps express a considerably changed view of the result of a prolonged or all-out attack on this country by thermonuclear bombs. The early information we had concerning thermonuclear bombs was of the great danger of radioactive fall-out which would theoretically sweep the entire nation in a downwind direction and the Civil Defense people had indicated the necessity of ten to fourteen days shelter protection for preservation of life against such fall-out. It now seems that the likelihood of this is less great than before thought. It



"ANYWHERE WILL DO --- JUST AS ITS FAR AWAY-
FROM PHONES AND PATIENTS!"

seems tactically more important, for the production of the greatest number of casualties, to explode a nuclear bomb at a great height. This causes a wider ring of total destruction from point zero and less dust and debris or radioactive fall-out, whereas a ground burst or low burst causes a smaller area but far greater dust and debris and radioactive fall-out. It is felt that the high burst would therefore be tactically correct and used. Since the fall-out problem would be less, then it would likely not be necessary to prepare for longer than three to four days protection against this fall-out and in some areas of less intensity even a normal home could be an adequate shelter, depending, of course, upon the intensity of the radiation.

Again, from the Civil Defense point of view, it is felt that the major casualties would result from thermal burns and from direct radiation and, third, from injuries resulting from low velocity objects rather than high velocity objects such as would be made by a shell fragment or rifle bullet.

Civil Defense preparation and disaster plans in this State are grossly inadequate due to many factors, the primary one being the excessive burden of cost and the fact that there has been no Civil Defense organization in this State, officially, until about one year ago. It is encouraging to know that we are now getting some organization in this State, but much more encouraging to know that the Federal Government, and the Army Medical Center in particular, have devised and planned many programs for the survival of the civilian population.

RECOMMENDATIONS

1. Full participation, through M.E.N.D., of its plan to have medical and hospital personnel take the Mass Casualty Course.
2. Cooperate with the Army Medical Corps in its plan to have all Junior and Senior medical students attend the Course.
3. Read the book "On the Beach"—or see the picture by the same name.

Respectfully submitted,
Charles R. May, Jr., M. D.

NEWS

Dr. J. Ralph Dunn announces the association of Dr. Perry Davis in the practice of medicine at 132 N. Washington Street, Sumter.

A recent article in the Florence, S. C. *Morning News* cited Dr. William Luther Byerly, Sr. as "Pee Dee Man of the Year" for his 45 years of service as physician to the people of Hartsville.

Dr. Byerly began his practice in Hartsville in 1915 and in 1924 he established a small clinic which later developed into Byerly Hospital. Today, the hospital has 127 beds.

The article quoted Dr. Byerly as saying: "In my 45 years in Hartsville, I have seen a miracle take place. No longer is South Carolina one of the plague spots. I speak particularly of . . . the vast strides forward in public health and the eradication of many diseases once peculiar to this section."

STOKES NAMED

Dr. J. Howard Stokes of Florence, is the new councilor-elect from South Carolina for Southern Medical Association. The council forms the governing body of the association.

One of the last official acts of the late Dr. Tom D. Spies as president-elect of Southern Medical Association was naming of four councilors-elect, of which Dr. Stokes was one.

A native South Carolinian, Dr. Stokes was graduated from the Medical College of South Carolina in 1931.

In addition to Southern Medical Association, Dr. Stokes holds membership in American Academy of Ophthalmology and Otolaryngology, American College of Surgeons and American Medical Association.

He is also a member of the South Carolina Society of Ophthalmology and Otolaryngology, serving as treasurer in 1948; South Carolina Medical Association, as councilor from 1942-1948; and chairman of education commissions, 1950; chairman of American Medical Educational Foundation 1958-59.

Dr. Stokes is married to the former Miss Helen Rhoad of Charleston. They have three sons.

NEW MEMBERS ON COLUMBIA HEALTH BOARD

The City of Columbia Board of Health's six new members attended their first meeting.

The six new members, appointed by City Council, are Thomas Chandler, Dr. L. Palmer Chappelle, Dr. E. C. Stevenson, Dr. Martin D. Young, Dr. Lee Sanders, and N. S. Skenes.

Other board members are Dr. E. C. Kinder, Mrs. Leon S. Bryan, Lloyd C. Hedgepath, Wilford P. Hendrix, Dr. E. K. Van de Grift, Jr., Dr. Raymond E. Christmus, T. E. McCutcheon, W. O. Onley and Bank.

Dr. Charles R. Sloan is city health officer.

TRI-STATE MEDICAL CONVENTION

The Tri-State Medical Convention held its 61st annual meeting at the Hotel Columbia March 21-22.

The two-day session included presentation of papers by convention members from the three states, North Carolina, South Carolina and Virginia. The group also elected new officers.

Those presenting papers included Dr. Edwin Boyle, Jr., Dr. Cheves Smythe, Dr. Rhett Talbert, Dr. Kenneth M. Lynch, Jr., Dr. Richard Sosnowski, all of Charleston; Dr. William Schulze, Greenville; Dr. Dana C. Mitchell, Jr., Columbia; Dr. George Johnson, Spartanburg.

Panel discussions were presented by Dr. Vince Moseley, Charleston; Dr. William Hendrix, Spartanburg; and by Dr. William H. Priolau, Charleston, Dr. Ben N. Miller, Columbia; Dr. Rawling Pratt-Thomas, Charleston.

Dr. Furman Wallace of Spartanburg was elected president of the Tri-State Medical Association.

Dr. R. B. Davis of Greensboro, N. C., was elected secretary-treasurer.

Dr. Wallace succeeds Dr. R. A. Ross of Chapel Hill, N. C.

COLUMBIA MEDICAL SOCIETY SEEKS EMERGENCY HOSPITAL

The Disaster Committee of the Columbia Medical Society yesterday took official action to get a 200-bed emergency hospital for the Columbia area.

The Army field-type hospital will be secured through the State Civil Defense Agency and the federal civil defense program.

The hospital will be ordered immediately, and will take from 60 to 90 days to arrive, according to Charles B. Culbertson, state CD director. It will be stored in the old nurses home at the Columbia Hospital.

The hospital will be used only in natural disasters or national emergencies, and will not be operated until then. It will definitely not call for hiring any additional personnel, it was emphasized.

The purpose of the hospital is to meet emergencies and the Columbia Medical Society has assumed the responsibility of providing the emergency hospital for the county.

When set up it will be a complete, 200-bed hospital with three operating rooms, X-ray units and an emergency power supply. The unit is designed for operation in existing buildings and will not be set up in a tent. It can be set up in four to six hours.

The Medical Society will sponsor the training of personnel to operate the hospital, and a practice emergency unit will be used for this. Greenville has the only training hospital at present; the unit will be rotated over the state for the same purpose.

York and Abbeville Counties have similar emergency hospitals and eight other counties have placed orders for them.

This unit was requested earlier, it was pointed out, but was delayed. Plans are being formulated for association with an organization or an individual to set up a team responsible for putting the hospital into operation in event of emergency.

Dr. James F. DeLoach announces the opening of his office for the practice of Internal Medicine at 190 North Whiskey Road, Aiken, S. C.

The Coastal Medical Society met Thursday, February 18, at the home of Dr. and Mrs. Carter P. Maguire, Charleston.

A Social Hour at 6:30 P. M. was followed by Dinner at the Lord Ashley Coach House.

DR. HOOK OPENS OFFICE

Dr. Marion B. Hook has announced the opening of his office at 1513 Hampton Street, Columbia, for the practice of general surgery and gynecology.

Doctor Hook received his education from the Columbia City Schools, and the University of South Carolina where he was a member of Phi Beta Kappa scholastic society.

He was graduated from the Medical College of South Carolina in June 1941 and served his internship at Maryland General Hospital, Baltimore, Md.

After completing his internship, he served with the Fifth Armored Division in Europe where he participated in five campaigns as battalion surgeon with the 81st Tank Battalion. He was awarded the bronze star for meritorious service.

Doctor Hook has been associated for the past 13 years with Dr. Alfred F. Burnside, Sr. in the practice of general surgery.

He is a member of the Columbia Medical Society, South Carolina Medical Association, American Medical Association and the Southern Medical Association.

MEDICOLEGAL MEETING AT CHARLESTON

The Law Science Academy of America conducted a legal institute on Medicolegal Aspects of Head, face and neck injuries in Charleston March 26-27.

The two-day course emphasized medicolegal trial technique. It was sponsored by the South Carolina Bar Association, the South Carolina Medical Association and the Charleston County Medical Society.

Eleven doctors and 15 trial counsels appeared on the program which was under the direction of Dr. Hubert Winston Smith, Chancellor of the Law Science Academy of America and professor of Law and Legal Medicine at the University of Texas Law School.

E. M. Dibble, M. D. and J. B. Berry, Jr., M. D. will be located in their new offices at 1115 North Main St., Marion.

At the Annual Meeting of the South Carolina Tuberculosis Association on April 6 in Columbia the following officers were elected for the S. C. Trudeau Society:

James W. Fouche, M. D., Columbia, President; Martin M. Teague, M. D., Laurens, Vice-President; Edmund R. Taylor, M. D., Columbia, Secretary-Treasurer. The Trudeau Society held its annual business and program meeting in conjunction with the meeting of the Tuberculosis Association. H. McLeod Riggins, M. D., President of the National Tuberculosis Association, was the guest speaker. Dr. Riggins' subject was "Present and Changing Concepts in the Treatment of Pulmonary Tuberculosis". Thirty members of the S. C. Trudeau Society attended the meeting.

Elected to serve a two year term as president of the S. C. Tuberculosis Association was Edward F. Parker, M. D., of Charleston. Dr. Parker succeeds John H. Martin of Hartsville who has served two terms. Dr. Parker has served on the board of the S. C. Tuberculosis Association for more than ten years. He has been a member of the board of directors of the NTA and presently is serving as a Representative Councillor on the governing council of the American Trudeau Society. I am enclosing for your information a copy of our Annual Report and a copy of the Program of the Association's Annual Meeting.

DR. B. N. MILLER CHOSEN AS DELEGATE

Dr. Ben N. Miller, Jr., of Columbia, was chosen to represent South Carolina on the governing body of the American Society of Internal Medicine, which held its annual meeting in San Francisco April 1 to 3. Dr. Miller attended the sessions as a delegate from the South Carolina Society of Internal Medicine. His alternate is Dr. Haskell S. Ellison, of Charleston.

FROM THE PAPERS

DANGERS OF FALLOUT

Addressing the recent meeting of the South Carolina Cancer Society, a physician Dr. T. A. Pitts said there is no reason for hysteria over the effects of radioactive fallout.

One result of all the emphasis on possible danger is that a growing number of people are afraid to take even simple x-ray chest examinations. The physician, an expert in the x-ray field, assured his listeners that

patients need have no worries about the medical use of the rays.

The body, he said, can take much more radioactivity than is generally realized. He cited a South Carolinian who had been treated with tremendous amounts. Not only was her crippling cancer cured, but she developed normally, became a champion athlete, married, and is now the mother of a normal, healthy child.

Radioactivity from fallout reached a record high after the Soviet Union's "dirty" bomb explosions in 1958, but the amount of radioactivity on the ground and in food supplies was still negligibly small.

One observer compared the alarm over fallout this way:

"If I start drinking two glasses of sherry a day instead of one, anyone can spread the news that I am now drinking twice as heavily. But such an increase is unlikely to affect my health. The same is so far true of radioactive fallout."

Actually, the entire human body is slightly radioactive, and this was true thousands of years before the advent of the nuclear bomb. Many foods contain radioactive chemicals.

Even if atomic bomb tests continue, their effect will be only a hundredth of that caused by cosmic rays from space that are constantly bombarding the earth.

People have flourished for centuries in the Andes, where the strength of cosmic rays is intense, and in India, where the soil is sometimes highly radioactive.

Because of its new and mysterious nature, the fallout from atomic bombs gets the headlines, but it is considered far less dangerous to health than the fumes that come from modern factories and machines.

Radioactive fallout could become a worldwide menace, but that will occur only during a full-scale atomic war, and then it would be secondary to the destruction created by the bombs themselves.

From *The State*

Columbia—April 6, 1960

HOSPITAL SERVICE

Retirement of Dr. Archibald J. Buist, Jr. as chairman of the Board of Commissioners of Roper Hospital has completed a dozen years of faithful service to the community of Greater Charleston.

As chief representative of the Medical Society of South Carolina, owner and operator of Roper Hospital, the chairman of the Roper commissioners has an important and arduous assignment. Dr. Buist has carried it out with vigor, intelligence and strict attention to duty. The community owes him gratitude.

Roper Hospital ably supplies a vital service which Charlestonians are fortunate to possess. Succeeding Dr. Buist as a member of the Board is Dr. Bachman S. Smith, Jr. We wish him well in a position of honor, trust and public service.

News and Courier

Charleston, April 9, 1960

DR. SIMPSON CONTRIBUTED MUCH

The recent loss of Dr. W. E. Simpson of Rock Hill was a deep and personal one for many persons, not only in this area but throughout the state.

Dr. Simpson was one of those people who sincerely tried to leave the world a little better than he found it.

A general practitioner's life is a busy one. But Dr. Simpson seized every opportunity to be active in civic, religious, and professional circles. He was a leader in his church, the Masons, and the medical profession.

But, aside from his profession, perhaps his greatest contribution was his work with the DeMolays, an organization sponsored by the Masons for young boys. Dr. Simpson was instrumental in forming the Rock Hill chapter and was the guiding force in this organization which strives to instill the young boys with religious and moral virtues they will carry through life.

The world would be a much nicer place in which to live if we all strived to make the contributions to our fellow man as did Dr. Simpson.

It would be a lofty goal.

The Evening Herald (pm)

Rock Hill, S. C.

COMPULSORY FEDERAL HEALTH INSURANCE WOULD LEAD TO SOCIALIZED MEDICINE

"Liberal" prescriptions for compulsory federal health insurance are being compounded for the next Congress in frightening volume. They contain little good medicine and a great deal of political sugar.

U. S. citizens compelled to swallow them should be prepared for violent reactions, ranging from simple bleeding of the pocketbook to paralysis of private medicine.

Political considerations rather than clinical arguments are winning support for compulsory health insurance among congressmen, even those who should recognize pure poison when they see it.

"A Democratic Congress certainly isn't going to stand idly by while the Republicans grab the ball and run with it on a politically potent issue," a leading House Democrat is quoted as saying.

Election year is a dangerous year for the nation when it comes to legislation with so many implications for the future, most of them bad. For the sake of votes, some Senators and Representatives may be willing to close their eyes and swallow any pill labeled "magic."

The "liberals" do not really care who supports their magic health bills as long as they are passed. What they are looking for is a foot in the door to socialized medicine. Either the bill being prepared by the Republican department of Health, Welfare and Education, or Rep. Forand, a Democrat of Rhode Island, will do the trick. Both of them offer a strong base on which to build an edifice of socialized medicine.

Both of them depend on the taxpayer for support.

Both of them deny patients a free choice of doctor or hospital.

Estimates of the cost range from more than a billion dollars to \$2 billion a year in the first year. How much higher the cost would go in the future, once the bureaucrats got rolling, is anybody's guess.

As usual when they are promoting the cause of paternalism, the "liberals" are talking about the "need" for federal health insurance. We believe they have invented the "need" to which they refer.

Though the number of older people who would benefit from federal health insurance is growing fast, so is the number of private insurance companies equipped to give them coverage. A reliable estimate is that 75 per cent of older people who need and want it will be covered by voluntary health insurance in 1965 and 90 per cent in 1970.

Of course, such figures do not interest the "liberals". They aim to place every American under compulsory, government-run health insurance whether they need it or not.

While they argue for a sure cure for everybody's ills, the health insurance quacks are really interested in doctoring free medicine. If the patient dies on the operating table, that will be good. The "liberals" will bury him without a trace.

Charleston News and Courier

SPURIOUS PRESENTS

Unfortunately some politicians never tire of thinking up spurious presents. For example, reports from Washington now indicate the chances are improving for Congressional approval next year of a compulsory health insurance plan for the aged.

This is the kind of thing that is difficult to discuss on unemotional grounds. The proportion of elderly in the population is rising. Medical costs are high. The community unquestionably has an obligation to care for the indigent aged whether they are well or sick.

The fallacy, it seems to us, is in proceeding from these premises to the conclusion that it is either necessary or wise for the Federal Government to take charge. For one thing, private health insurance for the elderly is becoming increasingly available. In the case of those who can't afford it, the proper order of responsibility, we think, goes like this: The family; if none, the resources of private charity; if that does not suffice, the local community.

When, instead, the Federal Government steps in with its compulsion and its higher taxes, the private resources are diminished. A vast addition to the bureaucracy is created, which means that much of the tax take will go for that. And the tax itself should not be underestimated; it is proposed that it be added to the Social Security levies which are mounting rapidly as it is. It would pile strain not only on the general taxpayer but on the system itself, and that system is already under strain and faces what may be impossible strains in the future.

But perhaps the most important point to consider before plunging into this sea without a floor is that

there is a choice. If the Government, instead of expanding its extravagant spending and so threatening poverty for all, would reduce its spending it could lower everybody's taxes and stabilize everybody's dollar.

Which is preferable: More bureaucracy, more taxes, more inflation? Or sound money and more money for the individual, the family, charity, and the community?

Which is the better gift for everyone—including the elderly?

Wall Street Journal

ANNOUNCEMENTS

THE DOCTORS' NURSES TO CONVENE

Doctors' Nurses Day on June 25 has been proclaimed by Governor LeRoy Collins of the State of Florida in honor of the first convention of the more than 2,500 members of the American Association of Doctors' Nurses. The session will be held on June 23 to 26 at Hotel Deauville, Miami.

The membership of the American Association of Doctors' Nurses is made up of young women who serve in doctors' offices as nursing assistants. The headquarters are in the Farragut Building, Washington, D. C.

YALE UNIVERSITY SCHOOL OF MEDICINE TO CELEBRATE SESQUICENTENNIAL

The Yale School of Medicine will celebrate a century and a half of existence on October 28 and 29 of 1960. The occasion will be marked by meetings, exhibitions, and addresses suitable to the occasion. Among a notable group of guest speakers will be Sir Howard Florey of Oxford, England. Complete details of the program will be announced later.

It was in October 1810 that the Connecticut General Assembly granted a charter to Yale College for the establishment of the Medical Institution of Yale College; the fifth medical school in the United States thus came into being. Unlike its predecessors the medical school was founded through impetus coming chiefly from within the College and not from a group of outside physicians.

The first medical faculty at Yale was a notable one, containing Eneas Munson, foremost authority on materia medica, Nathan Smith and Benjamin Silliman, still counted among Yale's greatest, Eli Ives and Jonathan Knight, leaders in medicine who were each to become President of the American Medical Association. From the start, the Connecticut Medical Society was a partner in the enterprise and worked in close cooperation all during the first half century of the School's existence.

Other events associated with the sesquicentennial celebration will take place during the academic year 1960-61. These include an exhibition of medical art at the Yale Art Museum and a scientific meeting to

be held in conjunction with the dedication of a new Medical School auditorium.

NINTH ANNUAL SYMPOSIUM for General Practitioners on Tuberculosis and other Pulmonary Diseases. July 11 through 15, 1960. Saranac Lake, New York.

Inquiries should be addressed to: Registrar, Symposium for General Practitioners on Tuberculosis and Other Pulmonary Diseases, P. O. Box 627, Saranac Lake, New York.

Sixth International Congress of Internal Medicine, August 24-27, 1960. Basle, Switzerland. Seventy leading internists from all over the world will take part in the main scientific programme. Official languages: German, French, English. Simultaneous translation for the principle lectures.

Programmes and registration forms may be obtained by writing:

Secretary,
International Congress of Internal Medicine
Steinentorstrasse 13
Basle 10, Switzerland

THE ARTHRITIS AND RHEUMATISM FOUNDATION

The Post-Graduate Seminar in Arthritis and Related Diseases which is to be held June 11th and 12th, 1960 immediately following the annual meeting of the American Rheumatism Association and immediately preceding the annual meeting of the American Medical Association. This course is acceptable for 8 hours Category I Credit by the Academy of General Practice.

SEMINAR COMMITTEE, Florida Chapter, ARF
1206 Huntington Medical Building
Miami 32, Florida

The Arthritis and Rheumatism Foundation offers predoctoral, postdoctoral and senior investigatorship awards in the fundamental sciences related to arthritis for work beginning July 1, 1961. Deadline for applications is October 31, 1960.

These awards are intended as fellowships to advance the training of young men and women of promise for an investigative or teaching career. They are not in the nature of a grant-in-aid in support of a research project.

The program provides for three awards:

- (1) *Predoctoral Fellowships* are limited to students who hold a bachelor's degree. Each applicant studying for an advanced degree must be acceptable to the individual under whom the work will be done. These Fellowships are tenable for one year, with prospect of renewal. Stipends range from \$2,000 to \$3,000 per year, depending upon the family responsibilities of the Fellow.
- (2) *Postdoctoral Fellowships* are limited to applicants with the degree of Doctor of Medicine, Doctor of Philosophy—or their equivalent. These Fellowships are tenable for one year, with prospect of renewal. Stipends range from

\$5,000 to \$7,000 per year, depending upon the family responsibilities of the Fellow.

- (3) *Senior Investigator Awards* are made to candidates holding or eligible for a "faculty rank" such as Instructor or Assistant Professor (or equivalent) and who are sponsored by their institution. Stipends are from \$7,000 to \$10,000 per year and are tenable for five years.

A sum of \$500 will be paid to cover the laboratory expenses of each Postdoctoral Fellow. An equal sum will be paid to either cover the tuition expenses or laboratory expenses of each Predoctoral Fellow. In the case of Senior Investigators, instead of the \$500, an additional 10% of the stipend will go to the institution to be applied to annuity programs, laboratory expenses, travel, etc.

For further information and application forms, address the Medical Director, Arthritis and Rheumatism Foundation, 10 Columbus Circle, New York 19, N. Y.

DEATHS

DR. J. C. BECKMAN

Funeral services for Dr. John Cornelius Beckman, a practicing Charleston physician for 47 years, were held March 22 in Charleston.

Dr. Beckman died at his home in Daytona Beach, Fla., where he had lived since retirement.

A native of Charleston, he was born September 12, 1884.

DR. W. B. TURNER

Dr. William B. Turner, practicing physician in Kershaw from 1913 to 1952, died in the Kershaw County Memorial Hospital in Camden on March 18.

Born in 1871, Dr. Turner was a graduate of the Medical College of South Carolina and a member of the South Carolina Medical Association and the Kershaw County Medical Society. For more than 30 years he was a trustee of the Kershaw city schools and served for two terms as Kershaw County Superintendent of Education.

Honorary pallbearers included members of the Kershaw County Medical Association.

DR. W. E. SIMPSON

Dr. William Elihu Simpson, of Rock Hill, S. C., died at his home March 10 after an illness of several months.

Dr. Simpson was born in Chester County in 1884 and was graduated from The Medical College of South Carolina in 1908. He was a past president of the South Carolina Pediatric Society, the Alumni Association of the Medical College of South Carolina, the Fifth District Medical Society, the York County Medical Society and the Rock Hill Medical Society.

BOOK REVIEWS

METABOLIC CARE OF THE SURGICAL PATIENT. By Francis D. Moorc, M. D. 1011 Pages. \$20.00. Philadelphia: W. B. Saunders Co., 1959.

The publication of this book by one of the leading investigators in the field of surgical metabolism is welcome. It compiles in one place the knowledge concerning metabolism of the surgical patient that has evolved in the past 20 years. The reviewer is relieved of the task of comparing this work with others in its field. Although the author's 1952 monograph, *The Metabolic Response to Surgery*, is its ancestor, there is no other comparable publication.

The author divides the book into 6 parts, the Normal Patient, The Blood Volume, Body Fluid and Electrolyte, Loss of Body Substance, Visceral Disease in Surgical Patients and Fractures, Wounds and Burns. An appendix on surgical diets and parenteral supplements is included. Most readers would probably be concerned with the first section on the normal patient and that section alone would justify the purchase of the book. One might question whether or not the last 2 sections of the book and the case histories should be included since they describe individual instances often not sufficiently adaptable generally to justify the space required. The book is written with a vein of dogmatism which may be of value to the casual reader who seeks help with the maze of chemical data forming the background of metabolic knowledge. For the more interested reader or the investigator, data are presented in the sections on Notes from the Literature.

The contemporary surgeon is involved daily with problems demonstrating the inseparability of operative management, surgical technique and metabolic care, which is the recurring theme of the book. Such involvement dictates the unqualified recommendation of the work to students who seek a view of surgical patients broader than that afforded by the operating room, to house officers who are trying to acquire surgical judgement and total patient care and to every physician who desires to enlist the aid of the patient's metabolism in his recovery.

Louie B. Jenkins, M. D.

SURGERY OF THE FOOT by Henri L. DuVries. R. V. Mosby Company, 1959. Price: \$12.50.

In this book Dr. DuVries presents a comprehensive study of the foot giving the normal anatomy of the foot, as well as a complete study of the various anomalies, both congenital and acquired. His treatment is sound and conservative.

This book is recommended for both the student and practitioner as a reference book. Its value lies in the fact that it is concisely written in an easily readable manner and the index is complete.

S. Edward Izard, M. D.

NAVY SURGEON by Rear Admiral Lamont Pugh. J. B. Lippincott, Philadelphia, 1959. Price: \$5.00.

This is an autobiographical account of the life of Dr. Lamont Pugh, formerly Surgeon General of the Navy. He gives a fairly detailed account of his life from the beginning to the present, and includes a great variety of action and adventure in all parts of the world and over the span of three wars. It makes interesting reading, and should be of special interest to those who are or have been or are about to be connected with the Navy in a medical way.

JIW

THE CIGARETTE HABIT: A SCIENTIFIC CURE by Arthur King. Doubleday & Co., Inc. Garden City, N. Y., 1959. Price: \$2.00.

The author who writes under the pseudonym of Arthur King is engaged in writing his Ph.D. dissertation on "The Social Psychology of Alcoholism". He is as much concerned with smoking as with alcoholism and was himself an addicted smoker who cured himself by the techniques which he presents here.

This book is not concerned primarily with the danger of smoking in regard to the production of cancer, but the author's concern is with the aspects of addiction, which are painted in very gloomy colors in the text. There are discussions of the way in which one becomes addicted and ways in which one may become unaddicted, with detailed directions for pursuing a somewhat complicated routine which includes the use of amphetamine, phenobarbital, and "Flavette" lozenges, which last are said to possess effective qualities and which appear rather often in the directions. This is essentially a do-it-yourself book and is not a really medical treatise. The reviewer can not find "Flavettes" among the recognized medical products.

JIW

A DOCTOR ENJOYS SHERLOCK HOLMES by Edward J. Van Liere. Vantage Press, New York, 1960. Price \$3.00.

The author has long been interested in the exploits of Holmes and Dr. Watson, and has contributed a number of papers on the subject over a period of years. This book is a readable series of essays which discuss the medical aspects of the many stories about the heroes. It touches on the use of knowledge of such things as curare, endocrinology, cardiology, and so on, and of the characters of the people in the stories. It shows Holmes as a scientist and gives a picture of Victorian medicine. Sometimes there is interpolated a certain amount of conjecture which can not be substantiated by knowledge of the time, and there is some comment on Dr. Watson's own version of medicine as he knew it.

This book should be meat for the Baker Street

Irregulars and the numerous other members of the cult of Sherlock Holmes.

JIW

A DOCTOR'S LIFE OF JOHN KEATS by Walter A. Wells, M. D. Vantage Press, New York. Price \$3.95.

Although John Keats embarked on a medical career, going through the necessary training to become an apothecary, and starting on a course for his doctorate, he never completed his design and left his course before his time was over. His poetic inclinations were notable during his medical training, and gradually replaced to all intent any interest he might have had in a medical life. He drifted through his studies at medical school and while he proved successful in his examinations he did not complete the necessary requirements. This book discusses at some length, in a rather staccato fashion, much of the medicine of Keats' times and wanders rather far afield from the main subject. Keats never applied his medical knowledge. He was a truant from medical school, not from medicine itself, as he never actually achieved the title of M. D. The book includes a considerable amount of conjecture and wanders into many byways which seem to have no definite connection with the main subject.

This book will probably be of more interest to the student of Keats than to the student of medicine.

JIW

HEARING: A HANDBOOK FOR LAYMEN by Norton Canfield, M. D., Doubleday & Co., Inc., Garden City, N. Y. 1959. Price \$3.50.

This is a book, written for the laymen, dealing with Otology, by an eminent Otologist. It is an attempt, and without any doubt, a successful one, to expose and air out the problems concerned with hearing impairment and its current treatment.

A frank and interesting discussion is made of the profound effect of hearing difficulties on the personality; the means of discovering the condition in children; the steps to be taken to ward off serious psychic sequelae.

The various types of hearing disorders are presented in a simple and accurate manner. The medical and surgical treatments and their indications are brought up to date; and hearing aids are discussed as to their indications and economic aspects.

A. L. Feuer, M. D.

CHRONIC ILLNESS IN A RURAL AREA, by Ray E. Trussell and Jack Elinson. Harvard University Press, Cambridge. 1959. Pp. 440. Price \$7.50.

A survey sponsored by the Commission on Chronic Illness in rural New Jersey began in 1952. In 1950 Hunterdon County had 43,000 people, 99% white, 25 doctors, no hospital, no town over 4500 people, per capita effective buying income equal to metropolitan

South Carolina counties. Five survey methods were used: questionnaire, family interview, verification by attending physician; clinical evaluation; multiple screening. Comparison of yield from clinical evaluation and family interview is the chief contribution to methodology. Sound, authoritative, sequential presentation is summarized in the opening chapter. This unique volume offers valuable information about major current trends: How prevalent is chronic illness and disability? How much could be prevented? How adequate is medical care today? How much rehabilitation is possible? The book can best be studied with three companion volumes from the same source: PREVENTION OF CHRONIC ILLNESS, CARE OF THE LONG-TERM PATIENT, and CHRONIC ILLNESS IN A LARGE CITY.

Malcolm U. Dantzler, M. D.

DRUGS OF CHOICE 1960-1961. Walter Modell, M. D., Editor. C. V. Mosby Company, St. Louis, 1960. Pp. 958. Price \$13.50.

Forty-seven contributors have combined efforts here to present 42 chapter topics which range through most of the areas of clinical practice. Typically, these include antibacterial agents, diuretics, analgesics, anticonvulsants, anthelmintics, antihypertensives, antiarthritics and topics grouped in terms of specialty interest, such as drugs used in obstetrics and gynecology, urology, dermatology, ophthalmology, etc. Eight new topics have been added since the 1958-1959 edition. The editor has been successful in enlisting some of the best recognized clinicians with experience in drug evaluation and there are also some representatives from the much smaller group of pharmacologists who can express firm opinions on the clinical status of the latest drugs. All of them have attempted the difficult task of bringing many new drugs into the same focus as older drugs with considerable background of trial and investigation. Frequently it is necessary to make the sweeping conclusion that the new variants are simple copies of the older compound with no basic improvements. Such a view, for instance, is offered for chlorothiazide (Diuril) which, pending further developments, is chosen in preference to the several hydrogenated and fluorinated derivatives promoted under a variety of new trade names. All these newer compounds, however, are faithfully listed and in that respect the volume is exceptionally current and complete. For instance, there is a special 5 page list of topical corticosteroids. Some few items would be challenged by the local group of pharmacologists. These include such statements as "Digitalis has no perceptible effects on cardiovascular function of the normal heart" and "the action of norepinephrine is primarily that of peripheral vasoconstriction with minimal direct cardiac effect." Such items of misinformation, however, are minor in view of the wide scope of sound information to be gathered from the book as a whole. Each chapter is followed by selected references which for the most part are the latest and most valuable. The

final 100 pages of the text are given over to a list of drugs with generic names, trade names, doses, routes of administration and manufacturers. This book can be highly valuable to anyone wishing a comprehensive current index of drugs with a critical perspective.

R. P. Walton, M. D.

A COOKBOOK FOR DIABETICS by Maude Behrman. American Diabetes Association, 1959. Price \$1.00.

A Cookbook for Diabetics by Deaconess Maude Behrman is accurate, well planned and well presented. The recipes are simple and easy to follow. There are pertinent facts for all diabetics to heed. The book is especially informative for an intelligent diabetic who craves a variety of food within his food prescription. The emphasis on fat, protein and carbohydrate to be used as a basis for diabetic calculation is to be commended; but I do wish the exchanges given for the recipes were as prominently listed as are the calories.

Mrs. Hillyer Rudisill
Therapeutic Dietitian

CHRISTOPHER'S TEXTBOOK OF SURGERY. Edited by Loyal Davis. W. B. Saunders Company. Seventh Edition 1960. Price \$17.00.

This new edition has numerous contributors with many chapters entirely new or completely rewritten including a new one on surgical judgment. The amount of information is truly encyclopedic for a single volume. The numerous illustrations are clear and to the point. Both general and topical aspects in the broad field of surgery are thoroughly covered. The chapter on surgical infections is quite up to date. This book is highly recommended for students, house staff and practitioners.

Fred Kredel, M. D.

NEW AND NONOFFICIAL DRUGS. J. B. Lippincott Co., Philadelphia, 1960. Price: \$3.35.

The annual appearance of this product of the Council on Drugs of the American Medical Association is always a welcome event. Certainly it would be impossible to keep properly posted on the drugs of the times without this volume for reference. It furnishes a brief and reliable account of the newer drugs and combines in this issue the chemical or technical names of the drug along with the trade name. With so much current conversation on the matter of the use of official or trade names, and what appears to be a rather concerted effort on the part of drug manufacturers to push the trade name as being more desirable than the official name, this book offers a means of getting back to original information and identifying the innumerable trade names with the proper substance to which a number of them may refer.

JIW

THE ACUTE MEDICAL SYNDROMES AND EMERGENCIES. Diagnosis and Treatment, by Albert S. Hyman, M. D., with the collaboration of Samuel Weiss, M. D., George G. Ornstein, M. D., Howard F. Root, M. D., Anna R. Spiegelman, M. D., and Jack Abry, M. D. Landsberger Medical Books, Inc. New York, 1959, 442 pages. Price \$8.75.

This book, in six sections, one by each of the collaborating authors, is a presentation of discussions of acute illnesses and emergencies involving 1) the cardio-vascular system, 2) the gastro-intestinal system, 3) the pulmonary system, 4) diabetes, 5) acute renal syndrome, and 6) barbiturate intoxication. Discussion of cardio-vascular and of gastro-intestinal problems, and of diabetes is well organized and informative, while in certain other sections poor organization and presentation is obvious. The section on acute renal disease in the copy examined is worthless, since a 32 page portion of the section on cardio-vascular illnesses is mistakenly bound into the section, omitting most of the material on acute renal syndromes and a portion of the following section on barbiturate poisoning.

Included in the book are discussions of diagnostic features, differential diagnosis and treatment of a variety of acute illnesses involving the various body systems. A chapter on cardiac resuscitation includes rather detailed discussion on problems related to, and management of cardiac arrest. As stated by the author in the introduction, "Most of the opinions expressed are results of personal experiences of the writers—" No bibliography is included and little reference to opinion of authorities in the various fields of discussion was noted.

Though certain portions are well done and much worthwhile information is presented, it is not felt that this book can be highly recommended.

MASTER YOUR TENSIONS AND ENJOY LIVING AGAIN, by George S. Stevenson, M. D. and Harry Milt. Prentice-Hall, New York. Price \$4.95.

George Stevenson, M. D. and Harry Milt combine their talents to produce a lucid and readable presentation of man's reaction to threats in his environment.

The oft-used word "tensions" is clarified so that the reader understands just what it means. Anxiety, that much maligned state, comes in for its share of attention. Clarification of these two words into simple, every day terms, is representative of Stevenson's work. The reader is not treated as if he were totally unsophisticated but neither is this work couched in excessively professional vernacular. Stevenson points the way to the constructive aspect of anxiety, likening it to a warning detection system. Just as tension is the reaction to threat (thereby mobilizing body—defense and self preservation activities) so too is anxiety a protective mechanism even though it appears in *anticipation* or expectation of a threat. Certainly man would not survive without these valuable partners.

The section dealing with the "shook-up" age is especially commendable.

Having defined and identified tension and anxiety

Stevenson discusses eight "tension-breakers" which are excellent goals of psychotherapy.

In the third section of his book Stevenson presents methods of avoiding tension—building situations which can do much to give insight to our relations with the important areas of our lives.

The real value of this work will be in its application to the large segment of our society which is not in immediate need of skilled professional care. I am somewhat hesitant to recommend "out-side-reading" to many of my patients because of their natural inclination to "quote-the-book" as a means if avoiding discussion of certain areas of their lives. Psychotherapy and certainly analysis can be seriously hampered when the patient becomes a self-trained psychiatrist. However, this book provides no clubs for beating therapists over the head. Nor does one find here the naive importuning to "snap-out-of-it" or "think good thoughts" so common to many less professional writers.

Most patients will benefit from the reading of this work. Indeed, the family physician will be benefitted by the uncluttered approach to many of the problems which are unhappily abandoned on his doorstep.

George H. Orvin, M. D.

THE SURGEON AND THE CHILD, Dr. Willis J. Potts, W. B. Saunders Company, Philadelphia, 1959. Price \$7.50.

This is a delightfully written book on pediatric surgery which should have a wide appeal. The style is simple, direct and quite human. All the common surgical problems in children are clearly described without undue attention to minute details of pathology and treatment. As might be expected from the accomplishments of the author, congenital anomalies of the heart and great vessels are excellently described. Disorders of the gastro-intestinal tract also receive outstanding attention. The illustrations, which are line drawings, are clear and to the point. The index is brief but adequate. Every doctor who treats infants and children should have this volume.

F. E. Kredel, M. D.

Prenatal care—The pale pink pill by L. L. Hester, Jr., M. D. (Charleston) J. M. A. Alabama 29:157 (November, 1959)

In an effort to prevent maternal complications and assure the delivery of a mature, healthy infant, this paper re-emphasizes the highly significant role of a good dietary regimen, and recognition of complications in their incipient stages.

The aims of prenatal care are enumerated: in essence, to gain the confidence of the patient: to encourage and develop a feeling of anticipation rather than one of fear in reference to the "ordeal" of labor; and to give the best physical prenatal care possible.

In place of the everyday prescribing of dietary supplements or "the pale, pink pill," the paper suggests good dietary habits listing basic requirements and essential foods. The low sodium diet (approximately

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When used alone, Aldactone will produce a satisfactory diuresis in about half of those patients whose edema is resistant to conventional diuretic agents.

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Research in the Service of Medicine

2 grams per day) is discussed as is the role of diuretics in the prevention of the ever dreaded syndrome of pre-eclampsia and eclampsia. Rapid weight gain is emphasized as being equally as important as blood pressure rise in the diagnosis of pre-eclampsia. Early hospital treatment is suggested for most rapid response and prevention of eclampsia or other complications, but most of all to assure delivery of a viable, healthy infant.

The usefulness of balanced anabolic steroid (Deladumone) therapy in osteoporosis resulting from bone injury by C. B. Hanna and W. D. Hastings, Jr., (Spartanburg) Current Therapeutic Research 1:130 (December 1959)

A series of 3 women and 9 men aged 27 to 65 years with osteoporosis resulting from bone injury of traumatic origin were treated with anabolic steroid therapy for periods of 2 to 6 months with a single injection of 1 ml. of Deladumone every 2 weeks. This dosage of the long-acting hormone preparation provides 90 mg. testosterone enanthate and 4 mg. estradiol valerate. In all 12 cases there was alleviation of pain, notable improvement in range of motion, and x-ray evidence of healing with a distinct increase in the density of calcium in the osteoporotic regions. In this study Deladumone was entirely free from unwanted masculinizing or feminizing actions, and without effect upon libido or urinary tract function. It is concluded that Deladumone is a practical therapeutic agent of value in the management of osteoporosis associated with traumatic bone injury.

Leiomyosarcoma of the duodenum: Case report and summary of the literature. Randolph Bradham (Charleston) Am. Surgeon 25:950-957, December, 1959.

Leiomyosarcoma of the duodenum is a rare lesion. It is a malignant tumor arising in the muscular layer and growing either into the lumen or on the outside of the wall. The usual growth pattern is outward. It rarely causes obstruction although it can attain great size. Many will undergo central necrosis and fistulization which may lead to hemorrhage, abscess formation, or perforation. Microscopic sections show whorls of spindle and fusiform cells which vary in size and show nuclear atypicalities and increased mitotic activity. Roentgenographic findings are rather characteristic and extremely helpful in diagnosis. Treatment consist of excision of the tumor with adequate margins of the duodenum and any invaded organs. The 53 cases previously reported are summarized. A case was added and discussed in detail.

Splenectomy for hypersplenism. R. R. Bradham (Charleston) South. M. J. 52:1544-1547, December, 1959.

Hypersplenism is a term rather universally used to indicate increased activity of the spleen. This may reflect itself by decreasing one or more cellular elements of the peripheral blood.. A group of these hematologic disorders which may be improved by splenectomy are discussed. They are considered to be "primary" when no other disease state co-exists and "secondary" when some other disease causes enlargement of the spleen. Several of these disorders cannot be classified as either primary or secondary. Prominent theories as to pathogenesis of hypersplenism are reviewed. Each disorder is considered from the standpoint of diagnosis, treatment, and prognosis. Important considerations in the technique of splenectomy are stressed. Close cooperation between hematologist and surgeon is essential in management of patients with these disorders.

Accidents: Child enemy number one. Julian P. Price, M. D. (Florence). West Virginia M. J. 56:60, Feb. 1960.

Dr. Price discusses the frequency and seriousness of accidents, and urges that greater attention be given to the subject at medical meetings, conferences, and seminars. Caution as to prescribing proper amounts of drugs, as to keeping drugs in safe places, and in education of parents is offered. The responsibility of the physician is stressed.

Radiation hazards in diagnostic roentgenology. By Harold S. Pettit, M. D. West Va. M. J. 56:55 (Feb. 1960).

Radiation is a destructive form of energy, but its dangers when it is properly applied have been exaggerated in recent years. Carelessly handled, it can injure the user or the patient, and I doubt that such injury to the patient in diagnostic work could be justified in court. Do not forget, however, that antibiotics, narcotics, hormones, and other drugs can be every bit as harmful to the patient if used improperly. In fact there are few materials used by physicians that would not be injurious if used carelessly.

Subtle and hidden genetic insults are of more concern, mainly due to the paucity of reliable information. At present, we have no good evidence to indicate that the small doses received in properly done diagnostic work have any effect. In spite of this, the possibility of mutations must be kept in mind in each examination undertaken, with the thought of reducing the dosage to the minimum. Use optimum technical factors, and use the fluoroscope sparingly before the end of the childbearing period. This applies particularly to fluoroscopy in children.

When in doubt about the advisability of a roentgen examination, consult your radiologist.

We always say "What is the treatment of this disease?" rather than "Is there a treatment for this disease." Even the expression "effective treatment" is a quaint one, we do not talk of "mobile motor-cars" we assume that they move, because that is their purpose and function. Logically we should not give treatment unless it is effective.

Deriving from this I obtain an uncomfortable concept which I believe to be true, but which I find too depressing to accept. This is it . . . "It is better to believe in therapeutic nonsense, than openly to admit therapeutic bankruptcy." Better, in the sense that a little credulity makes us better doctors, though worse research workers.

I find this one of the most uncomfortable concepts that logical reasoning leads me to. If you admit to yourself that the treatment you are giving is frankly inactive, you will inspire little confidence in your patients unless you happen to be a remarkably gifted actor, and the results of your treatment will be negligible. But if you can believe fervently in your treatment, even though controlled tests show that it is quite useless, then your results are much better, your patients are much better and your income is much better too. I believe this accounts for the remarkable success of some of the less gifted, but more

credulous members of our profession, and also for the violent dislike of statistics and controlled tests which fashionable and successful doctors are accustomed to display. It is an almost insoluble problem, and the majority of worth-while doctors are driven to a compromise, in which they muster enough genuine belief in their treatment to keep their patients happy and maintain their own self respect, while preserving enough doubt to admit their inadequacy during transient bouts of uncomfortable honesty.

—"Sense and Sensibility", Richard Asher,
TRANS. MED. SOC. LOND 75:66

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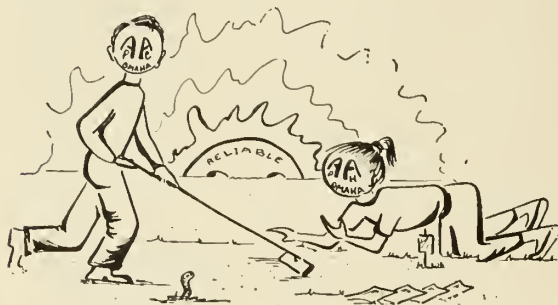
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THE GEOGRAPHIC DISTRIBUTION OF MULTIPLE SCLEROSIS

A COMPARATIVE STUDY IN CHARLESTON COUNTY, SOUTH CAROLINA
AND HALIFAX COUNTY, NOVA SCOTIA

I. Prevalence in Charleston County, South Carolina

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There is a widespread impression that multiple sclerosis is less prevalent in warmer climates than in colder regions. Davenport¹ as early as 1922 suggested this in a report based on United States Selective Service data where he showed that the disease was diagnosed most frequently in draftees from those States bordering on the Great Lakes. Other authors have reported differences in geographic distribution in North America^{2,6} and in Europe^{7,9} which suggest a greater prevalence in more northerly communities. It is difficult to compare prevalence estimates on the basis of these reports because of the variability in methods used by the different investigators. More comparable data are needed to determine the influence of geographical factors such as climate on the prevalence of multiple sclerosis. Therefore, a comparative study of its prevalence in two widely separated communities by the same team of investigators was planned. In addition to clarifying the influence of geographic fac-

tors on frequency, such a study should permit a comparison of the clinical characteristics of the disease in the two areas. Charleston County, South Carolina and Halifax County, Nova Scotia were selected for such a comparative study. Both communities are located on the Atlantic coast near sea level. Both have long-established medical schools. The white population of both is predominantly of Western European origin. Additional pertinent comparisons are shown in Table I.

The present report describes the method of investigation employed in this study and summarizes the results in Charleston County.

Method

The survey was conducted in Charleston County from November, 1956 through March, 1958. In order to estimate the *prevalence rate* of multiple sclerosis in the county, an attempt was made to determine the number of patients residing in the county on an arbitrarily selected date, December 31, 1955. Patients were excluded if their symptoms began after

TABLE I
Some Characteristics of Halifax, N. S. and Charleston County, S. C.

Community	Total Population, 1955*	Racial Composition		Climate		Physician/Population Ratio	Hospital Bed/Population Ratio
		White	Negro	Mean Temp. °F.	Jan. July		
Charleston County	188,000	94,000	94,000	50.9	81.5	1:810	1:235
Halifax County	198,000	190,000	8,000	24.0	64.7	1:905	1:188

*Charleston County Planning Board Estimate, December 31, 1955, and census of Halifax County, January 1956.

"prevalence day" or if they died before this date.

Only patients living in the county for at least one year prior to "prevalence day" were considered residents of the county for this study.

Sources of Information

Hospital Records: Medical students who were trained and supervised throughout the study inspected diagnostic files and the diagnostic face-sheet of records of all admissions to the hospitals in the county during the decade ending December 31, 1955. Those records were collected on which any of a selected list of neurological diagnoses occurred, including.

Multiple Sclerosis
Optic neuritis or retrobulbar neuritis
(Primary) lateral sclerosis
Cerebellar ataxia
Paraplegia
Myelitis, myelopathy, or encephalomyelitis.

The five diagnostic categories in addition to multiple sclerosis were selected because of their resemblance to common clinical forms of multiple sclerosis and in an effort to avoid missing cases because of possible variations in diagnostic nomenclature.

Outpatient Clinic Records: Since these records lacked either a coding system or a diagnostic face sheet they were scrutinized in greater detail by the medical students. Records containing notation of neurological symptoms or signs consistent with multiple sclerosis were collected.

Experience of Medical Practitioners: At the initiation of this study the participation of the doctors in the community was solicited through the Charleston County Medical Society. In appearances before this society, the investigators informed the doctors of the purpose and progress of the study and requested their assistance in locating cases. Of the 191 Doctors of Medicine listed in Charleston County, 152 were in clinical practice. Form letters were sent to each of the latter inquiring whether, in the previous five years, he had observed any patients with multiple sclerosis, optic or retrobulbar neuritis, cerebellar

ataxia, primary lateral sclerosis, myelitis, myelopathy, encephalomyelitis or undiagnosed paraplegia. Replies were received from 134 (89 per cent), of whom 37 (27.6 per cent) reported relevant cases.

Death Certificates: Although cases from this source prior to December 31, 1955 were not pertinent to the estimate of prevalence, such data were of value in indicating which patients had died, the duration of the disease among those recently deceased in this community, and the extent to which patients in whom multiple sclerosis had been diagnosed had this disease listed on the death certificate. All death certificates for the decade ending December 31, 1955 were examined.

Autopsy Records: The records of necropsies performed from January 1, 1946 to December 31, 1957 in the Department of Pathology of the Medical School were scrutinized. No case was found in which the pathological diagnosis of multiple sclerosis was made.

Miscellaneous Sources: Personal inquiry was made of the Visiting Nurses of the Charleston County Health Department, members of local health organizations (Crippled Children Service, Muscular Dystrophy Association), and others during the course of the study as to their knowledge of cases of multiple sclerosis.

A total of 187 "provisional" cases diagnosed as multiple sclerosis or one of the clinically similar disorders designated above were ascertained. The sources from which they were derived are indicated in Table II:

TABLE II Source of Provisional Cases		
	Number	Per Cent
Hospital and Outpatient		
Clinic Records	110	59.0
Practitioners	49	26.1
Vital Statistics	5	2.6
Multiple Sources	15	8.0
Miscellaneous Sources	8	4.3
	187	100.0

Subsequent information acquired from detailed scrutiny of records, preliminary interviews with patients or acquaintances, and

death certificates necessitated discarding 114 of the cases for the following reasons:

Misfiled as multiple sclerosis or final diagnosis of other neurological disease	33
Failure to qualify as residents	38
Died prior to "prevalence day"	36
Symptoms began after "prevalence day"	7
	114

There remained a total of 73 cases about which there was information compatible with the diagnosis of multiple sclerosis. Seventy of these were examined personally by one or more of the authors, most of them by a team of two (M.A. & R.S.A.) Each case was discussed and, by mutual agreement based on combined clinical judgement rather than any rigid formula of signs or symptoms, each was either discarded or assigned to one of the diagnostic groups defined below.

Diagnostic Criteria

Since the diagnosis of multiple sclerosis rests largely on clinical judgement rather than laboratory findings, a study of this type necessitates the adoption of clinical criteria for diagnosis. A modification of criteria used by Allison and Millar⁹ was formulated before any patients were seen and served as the basis for classifying each case.

Group I—Early probable multiple sclerosis: This included patients with slight or no disability and few physical signs but with a history of remitting symptoms of the kind commonly associated with the onset of multiple sclerosis, e.g. transient unilateral blindness, diplopia, vertigo, ataxia, numbness or weakness in one or more limbs.

Example:

R.D. No. 19C. In 1951 when 26 years old this white woman lost vision in the right eye. A diagnosis of retrobulbar neuritis was made. Vision returned in one month. In 1956 she developed headaches, cramps in the legs, a sense of inward shaking, and walked "as if drunk". Examination at that time showed nystagmus. When examined by us in 1957 she showed slight intention tremor on the left finger-to-nose test, and increased tendon jerks in the upper limbs but had no disability and was able to carry on full activities.

If abnormal physical signs were absent when examined, the patient was excluded. Patients who were not available for examination were accepted only when there was documented proof of symptoms and abnormal physical signs. Retrobulbar neuritis alone was not con-

sidered as early multiple sclerosis in this study.

Group II—Probable multiple sclerosis: Patients in whom there was no reasonable doubt as to the diagnosis of multiple sclerosis were placed in this group. They had some degree of disability, usually a remitting history and, on examination, had definite physical signs explicable only on the basis of multiple lesions of the neuraxis.

Example:

S. C. No. 10 C. At the age of 26 years, between 1944 and 1945 this white woman developed numbness in one hand. In 1946, vision in the left eye became impaired and a diagnosis of retrobulbar neuritis was made. Vision improved, but in 1948, the right eye was affected similarly and paresthesias in the left arm occurred. The following year her walking became affected. In 1955 she was incontinent of urine for a short period. When examined in 1957, she showed marked emotional lability, pale optic discs, terminal intention tremor on the right, and horizontal nystagmus. Spastic paraparesis was present with no objective sensory loss.

Group III—Possible multiple sclerosis: Patients classified in this group had some physical disability and signs indicative of disease of the neuraxis which was suggestive of multiple sclerosis. The course of the disease had usually been static or progressive and physical signs did not provide sufficient evidence of *multiple* lesions. No other cause for the disorder could be found.

Example:

M. B. No. 140 C. A colored woman aged 64 with excellent recall of past events. Onset 1936-37, aged 43, with stiffness and weakness in the legs, which was only slowly and gradually progressive. Sphincter disturbances since 1947, but in 1957 still only occasionally incontinent. The possibility of multiple sclerosis was first raised in 1947. Cerebrospinal fluid and blood were normal. No previous history of syphilis. She was still able to do housework although moderately disabled in walking. On examination in 1957, she had well preserved intellect and normal affect, and was pleasant and cooperative. Optic discs were normal. Eye movements were full. No nystagmus or pupillary abnormality was found. Jaw jerks were not increased but arm jerks were increased. She had spastic paraplegia with exaggerated knee and ankle jerks and extensor plantar responses. Defective postural joint sensibility in the great toes and loss of vibration over the lower limbs, sacrum and iliac crests was demonstrated. Touch and pain sense were well preserved.

Of the 73 cases considered for prevalence, 47 (64 per cent) were discarded on diagnostic grounds, in-

cluding 6 cases with retrobulbar neuritis as the only manifestation of neurologic disease.

Results

Twenty-six cases were accepted as multiple sclerosis in one of the three diagnostic groups. Table III shows the distribution in the separate groups according to race and sex.

TABLE III
Distribution of accepted cases according to race and sex

	White		Colored		Total Cases
	M	F	M	F	
Early probable multiple sclerosis		4	1		5
Probable multiple sclerosis	4	6	1		11
Possible multiple sclerosis	2	2	3	3	10
	6	12	5	3	26

The *prevalence rate* for multiple sclerosis in Charleston County based on the 26 cases is 13.8 per 100,000 population. Exclusion of the patients classified as "possible multiple sclerosis" would give a prevalence rate of 8.5 per 100,000 population.

Age specific prevalence rates (Table IV) indicate an increasing frequency of the disease through the sixth decade. Since the mean age at onset was 30.8 years, this is an indication of the chronicity of the disorder, for the proportion of patients to population tends to increase as the population ages.

The *prevalence ratio* by sex was 1.4 female cases to 1 male.

Prevalence rates for whites and Negroes suggest the possibility of greater prevalence in the white population. Eighteen of the accepted cases were white and 8 were colored, whereas the population at risk was equal for the two races. However, the number of cases in both groups was small and the difference in the number of cases found is not statistically significant (CHI square=3.1)

A spuriously low prevalence rate would re-

sult if the disease manifested itself differently in warm regions. To test this possibility, the clinical characteristics of the accepted cases were analyzed. The *age of onset* ranged from 13 to 58 years with a mean of 30.8 years. The *mean age on prevalence day* was 43.7 years. The *duration of illness* ranged from 2 years to 34 years with a mean of 12.9 years. The *general course of illness* in 19 patients (73 per cent) was remitting and in seven (27 per cent) was progressive. The *relapse rate* in the remitting cases was 0.37 relapses per person-year of illness, or approximately one relapse every three years in the average patient (based on 15 patients on whom information was available with an aggregate of 130 patient-years of illness).

Although a patient was considered a resident of the county after having lived there at least one year on prevalence day, it should be emphasized that 92 per cent of the Charleston patients were natives of Charleston County and 77 per cent developed their initial symptom while residing in this county.

Discussion

There are relatively few studies of multiple sclerosis prevalence in Southern United States. Van Wart¹³ in 1905 thought that multiple sclerosis in New Orleans was common, reporting that 4.4 per cent of the patients attending his clinic were diagnosed as having this disease. Steiner¹⁴ who worked in that area some twenty years later disagreed and felt that it was much less common in New Orleans than in the Northern United States. Kurland and Westlund¹² reported a prevalence rate of 13 per 100,000 white population and 8 per 100,000 Negro population in New Orleans, comparable to the rate in Charleston determined in the present study. This is in contrast

TABLE IV
Age Specific Prevalence Rate for Multiple Sclerosis in Charleston County (December 31, 1955)

	Age Group							Total
	0-9	10-19	20-29	30-39	40-49	50-59	60	
Estimated Population*	44,000	32,000	36,000	29,000	20,000	13,000	14,000	188,000
Number of Patients	0	1	4	4	8	6	3	26
Prevalence Rate per 100,000 Population	0	3.1	11.1	13.8	40.0	46.2	21.4	13.8

*Charleston County Planning Board Estimate for December 31, 1955.

to the higher prevalence rates reported in the past in northern communities.

The apparently low prevalence rate in Charleston County cannot be accounted for by any difference in the course of the disease from that generally described. The clinical characteristics studied are not appreciably different in the cases accepted in this study from those characterizing multiple sclerosis elsewhere. Furthermore, the apparent failure of this climate to modify the course of the disease (as judged by age at onset, duration, and relapse rate) does not support the view that a change of residence to warmer regions is likely to improve the outcome of the disease among patients who develop multiple sclerosis in the North.

Additional studies using careful and comparable case finding techniques in communities in southern latitudes and studies of prevalence in areas below the equator are needed to establish as fact that multiple sclerosis has an uneven geographic distribution. If this can be shown to be true, an important characteristic of multiple sclerosis will have been demonstrated which may provide important clues to its etiology.

Summary

In a survey of all pertinent sources of medical information in Charleston County, South

Carolina, 26 patients with multiple sclerosis were found living in the county on December 31, 1955 (prevalence day), giving a *prevalence rate* of 13.8 per 100,000 population. Age-specific prevalence rates showed an increasing frequency of the disease in the community through the sixth decade. Although fewer cases were found among negroes, the difference in prevalence between Negroes and whites is not statistically significant.

Certain clinical characteristics of the disease such as age at onset, duration of illness, severity of disability, general course and relapse rate among remitting cases were described. These suggest that the disease in this Southern community did not differ in these respects from what has been described in other areas further to the north.

A similar study, utilizing the same techniques and diagnostic criteria, has been completed in Halifax, Nova Scotia. A comparison of the results obtained in these two communities is in preparation.

Acknowledgments

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THE SOUTH CAROLINA OBSTETRICAL AND GYNECOLOGICAL SOCIETY

PAPERS PRESENTED AT COLUMBIA, S. C.

OCTOBER 12, 1959

MATERNAL MORTALITY IN SOUTH CAROLINA REVIEW FOR 1957

ROBERT M. READ, M. D.

and the

MATERNAL AND CHILD HEALTH DIVISION;
STATE BOARD OF HEALTH

Maternal death is defined as the death of any woman who is pregnant or dies within ninety days of the termination of pregnancy regardless of the cause of death. This definition will, of course, include deaths which are of no significance in this study, such as traumatic deaths where the presence of pregnancy would have no effect on the outcome.

In the state of South Carolina, although the maternal death rate has been reduced somewhat over the past decade, it is still high in comparison with the national average. In an attempt to determine the causes of our higher death rate, a committee on Maternal Health composed of both general practitioners and obstetricians was established a number of years ago. When a maternal death occurs, all the available information is obtained by means of questionnaires and letters which are sent to the physicians who signed the death certificates and to all consultants. When the information is complete, a summary is made and copies are sent to the committee members and to the physician involved. At regular intervals, usually every other month, the committee meets and the cases are discussed. The physician who is involved is invited to attend the meeting so that he can contribute to the discussion. It is the purpose of these meetings to determine the cause of death, and if any, the preventable factors involved. It is not the desire of the committee to fix blame or to criticize. Rather it is hoped that insight into the

This is the annual review of maternal mortality in South Carolina. The maternal death rate in this state is still high in comparison with the national average, although it has been reduced somewhat in the past decade. The total of 67 deaths was reported for the year 1957, which this paper covers. Of these deaths, 31 were judged to be preventable, and 11 were attributed to the physician's faulty diagnosis or treatment.

The critical analysis of maternal deaths can lead to reduction of the death rate, and this annual survey of the situation in South Carolina gives valuable aid to the effort to push the death rate to the irreducible minimum.

causes of death will benefit others in similar situations. It is also our belief that statistical analysis will be of benefit. With these facts in mind the statistics for 1957 are presented.

The statistics for 1955-1956 have previously been compiled and presented by Dr. Harry Temple and Dr. Frank Strait. They will be used in comparison with 1957 statistics to point out significant changes.

Table 1A is a tabulation of the primary causes of death. As there were often two or more equally important causes of death, the total is greater than the total number of cases. Table 1B is a percentile comparison of major causes of death in 1955, 1956, and 1957. From this one can see that uterine hemorrhage as a cause of death has decreased from 44% in 1955 to 31% in 1956 and 28% in 1957. It is also noted that there has been a steady de-

TABLE 1—PRIMARY CAUSES OF MATERNAL DEATHS IN 1957

Uterine hemorrhage	18
Toxemia (eclampsia) (13)	15
Infections	8
Cardiac failure	7
Ruptured ectopic	6
Pulmonary embolism	5
Cerebral hemorrhage	5
Chronic pyelonephritis	1
Anesthesia	1
Anemia, chronic	1
Total	67

TABLE 1A—PRIMARY CAUSES OF MATERNAL DEATHS

	1955	1956	1957
Hemorrhage	44%	31%	28%
Toxemia	30%	27.4%	23.4%
Infection	5.3%	3.9%	12.5%
Pulmonary Embolism	16.1%	15.7%	7.8%
Cardiac Failure	1.8%		10.9%

crease in the incidence of toxemia, from 30% in 1955 to 27.4% in 1956 and 23.4% in 1957.

In contrast, infection as a cause of death has markedly increased from 3.9% in 1956 to 12.5% in 1957. A similar increase in cardiac failure from 1.8% in 1956 to 10.9% in 1957 is noted. Other causes appear to vary only slightly except for pulmonary embolism, which shows a significant decrease.

Because of the small number of cases evaluated, it is hard to read significance into these figures. However, a definite trend can be seen in the yearly decrease in the incidence of toxemia and uterine hemorrhage, which together comprise 51.4% of the maternal deaths in 1957. This is due to a number of factors, which include better and early prenatal care, earlier hospitalization and expansion of the blood bank system.

As noted above there was a marked increase in infection. Analysis of the 8 cases revealed 4 of the 8 to be septic abortions, 2 postpartum infections, one case of infectious hepatitis and one case of acute pyelonephritis with septicemia.

The incidence of death from ruptured ectopic pregnancy when it is diagnosed early and where blood is available should be low, except where patient delay results in a hopeless situation. In 1955, 1956 & 1957 the incidence for ectopic pregnancy as a cause of maternal death was 3.0%, 1.9% and 9.2% respectively. In analyzing the preventability it

was found that the physician was deemed responsible in 2 of the 6 cases, 2 were unclassified due to lack of information and 2 deaths were due to patient delay.

There were 64 maternal deaths in 1957. Table 2A shows the distribution of deaths as to race and incidence. It is interesting to note that the death rate among the colored race was over 5 times as high as among the white race. There were 62,942 live births in 1957 of which 35,425 were white and 27,417 were Negro. The maternal mortality rate (incidence per 1000 live births) was 0.3, or 1 death to every 2952 live births for white, and 1.9 or 1 to 529 live

TABLE 2A—RACE DISTRIBUTIONS

No information	2
White	11
Negro	51
Total	64

TABLE 2B—INCIDENCE OF MATERNAL DEATHS

1955 White	1:6975	Negro	1:454	Comb.	1:941
1956 White	1:2717	Negro	1:742	Comb.	1:1245
1957 White	1:2952	Negro	1:529	Comb.	1:983
1955 National Average 1:2631					

births for Negroes. This gives a combined rate of 1 death for every 983 live births. The increase in the death rate as compared with 1956 can be accounted for by an increase in the Negro segment. In 1955 this discrepancy between races was even more dramatic with 1 death for every 454 live births among Negroes and 1 death for every 6975 live births for whites. In this regard it is interesting to note that of the 35,425 white live births 34,710 mothers were delivered in hospitals and only 126 had midwives in attendance. In contrast, of the 27,517 Negro live births, only 14,380 mothers were delivered in hospitals while 9,896 were delivered with midwives in attendance.

As can be seen from Table 3, which shows the outcome of pregnancy, 40 patients were delivered prior to death. Of these women, 22 or 55% delivered live born infants. Eleven of the 64 were undelivered at death. The remaining 13 cases were abortions and ectopics and three for which insufficient information was available.

Table 4 shows the relation of death to pregnancy. Fifty nine and three tenths per cent of

TABLE 3—OUTCOME OF PREGNANCIES

Delivered	40
Stillborn	15
Liveborn	22
Unknown	3
Abortion	5
Ectopic	5
Undelivered	11
Unknown	3
Total	64

TABLE 4—RELATION OF DEATH TO PREGNANCY

Antepartum	12
Intrapartum	2
Postpartum	38 (59.3%)
Abortions	5
Ectopics	4
Unknown	3
Total	64

the women died postpartum. Only 2 of the 64 patients died intrapartum. One of these was a 26 year old colored female who apparently delivered spontaneously at home unattended by a physician. Autopsy revealed partial placenta previa. The second case was that of a 37 year old white female who had convulsions during labor. She died en route to the hospital.

Physicians were in attendance at 54 of the 64 deaths, midwives were attending in 8, in two of which the midwife was partially or wholly responsible for the maternal death. One case is that of a 32 year old colored female, para 7, who was allowed by the midwife to labor for 48 hours. A stillborn infant was delivered with retained placenta occurring. When the physician was called in, the patient was in deep shock, she had a distended abdomen and no external bleeding. She was admitted to the hospital and manual removal of the placenta was accomplished. At that time a large rent was discovered in the uterus and a hysterectomy was performed, but the patient died before the abdomen was closed. Another case was that of a 38 year old colored female delivered at home by a midwife. Apparently a small portion of placenta, attached to the cord, was delivered and the midwife left. Later the patient was carried to the hospital in extremis where almost the entire placenta was delivered. Transfusion failed to reverse the deep shock and the patient died.

Of the 64 deaths there was adequate information concerning prenatal care in only 41. Table 5 illustrates the amount of care

given. From this table it is evident that less than one half of the patients received adequate prenatal care. This is one area in which the public could be educated to greater advantage. In the great majority of cases of inadequate or absent prenatal care, the patient alone was responsible. In this respect it is probable that the maternal mortality rate could be reduced with more adequate prenatal care.

Table 6 represents the breakdown in legitimacy. Forty-eight mothers were married, 11 unmarried and the marital status of 5 was unknown.

Table 7 gives the age and parity of the mothers. Parity ranged from 1 to 9 among white and 1 to 4 among Negroes. Age ranged from 17 to 38 in whites and 14 to 44 in negroes.

As seen in Table 8, approximately 70% of the deaths occurred in hospitals, although in some cases the patient was in extremis on arrival. In 25% death occurred at home.

Table 9 shows that 59% of the patients were service cases and 31% were private.

As previously seen in Table 1 toxemia accounted for almost 25% of the maternal deaths. Table 10 shows the breakdown into types of toxemia and further illustrates the frequency with which toxemia is involved, either as the primary cause of death or as a contributing factor. It is interesting to note that toxemia occurred in 30 or the 64 cases.

TABLE 5—PRENATAL CARE

Adequate	19
Inadequate	15
None	7
Unknown	13

TABLE 6—LEGITIMACY

White deaths	12	Negro Deaths	52
Legitimate	11	Legitimate	37
Illegitimate	0	Illegitimate	11
Unknown	1	Unknown	4

TABLE 7—AGE AND PARITY

	White	Negro
Primiparas	1	9
Multiparas	10	28
Unknown	1	15
Parity range	1-9	1-14
Age range	17-38	14-44

TABLE 8—LOCATIONS

Home	16 (25%)
Hospital	45 (70.3%)
Unknown	3

TABLE 9—STATUS

Private	20 (31.25%)
Service	38 (59.3%)
Unknown	6

thus being involved in 47% of all maternal deaths. Of these it was the primary cause of death in 15 (23.4%) and a contributing factor in 12 (18.1%). Thus, it would appear evident that better control of the acute toxemias such as pre-eclampsia and eclampsia which accounted for the great majority of the toxemias, would reduce the mortality rate. This again is

TABLE 10—TOXEMIA			
	Negro	White	Total
Hypertensive Vas. D.	8	1	9
Pre-eclampsia	13	2	15
Eclampsia	8	5	13
Primary	10	5	15 (23.4%)
Contributing	10	2	12 (18.1%)
Non-contributing	2	1	3 (4.7%)

directly related to the adequacy of prenatal care as well as the promptness of adequate therapy. It is also evident that the treatment of eclampsia should be stressed, as of the 15 deaths attributed to toxemia, 13 were eclamptic toxemias. There are many different regimens of therapy, some of which are totally inadequate. It is realized that some of these patients are seen too late to treat adequately but others could be saved by prompt and vigorous therapy. An attempt to disseminate knowledge of the latest method of therapy to the physicians of the state should be made as this is one way in which a steadily declining death rate could be further reduced.

Hemorrhage as a primary cause of death was present in 26 cases and was a contributing factor in 2 additional cases. The different forms of hemorrhage are illustrated in Table 11. As previous studies have shown, the most

TABLE 11—HEMORRHAGE			
	Negro	White	Total
Primary	23	3	26
Contributing	2	1	3
Uterine atony	6	1	7
Ruptured ectopic	6	0	6
Cerebral hemorrhage	4	1	5
Retained placenta	2	0	2
Placenta previa	1	0	1
Abruptio placentae	3	1	4
Ruptured uterus	2	0	2
Placenta accreta	1	0	1
Undetermined	0	1	1

common cause of hemorrhage was postpartum atony.

A more unusual cause of uterine hemorrhage is hypofibrinogenemia, usually associated with abruptio placentae. This was seen in 3 cases in this series. It is usually unrecognized and because of this is dangerous. It is often mistaken for uterine atony and treated as such.

Ruptured uteri occurred in two cases, one of which has already been discussed. Placenta accreta occurred in one case, cerebral hemorrhage 5 times and ruptured ectopic pregnancy six times.

TABLE 12—PREVENTABILITY		
Unclassified	20	
Non-preventable	13	
Preventable	31	
Facilities		5
Pt. & Family		20
Dr. Management		11
Midwife		3

As is illustrated by Table 12, an attempt to judge the preventability of maternal deaths was made. Preventability can be assigned only in light of ideal circumstances, thus some cases were deemed preventable because of lack of facilities. Thirty-one deaths were judged preventable. Of these, 11 deaths were due to the physician's misdiagnosis or mis-treatment. In 20 cases the patient and the patient's family were responsible for the fatal outcome due to delay in seeking care. In 3 cases midwives were judged responsible and 5 deaths were due to lack of facilities.

It is a well demonstrated fact that the critical analysis of maternal deaths can lead to reduction in the death rate. With the continued cooperation of the physicians of South Carolina, we believe that our maternal mortality rate can be further reduced in the future. We would like to take this opportunity to thank those who have cooperated in the past. We can only hope for increased cooperation and help in the future.

THE AGGRESSIVE MANAGEMENT OF THE INFECTED ABORTION

A 2 YEAR COMPARATIVE STUDY

W. FRANK STRAIT, III, M. D.
ROCK HILL, S. C.

Introduction

Abortion is one of the most common problems confronting the obstetrician-gynecologist. Among patients with abortion, infection is one of the most frequent complications encountered.⁶ In a series of 7000 abortions studied in a 15 year period at Bellevue Hospital, 357 had clinical evidence of infection of varying severity.⁴ Some authors consider the uterine cavity to be infected in all cases of incomplete abortion, whether spontaneous or induced, even in the absence of fever.²

In recent years a more aggressive management of the patient with an infected abortion has been evident over the country.^{1, 2, 4, 6, 7} Reported results have been satisfactory. The more conservative policy traditionally accepted at the Medical Center Hospitals in Charleston, S. C. has been subjected to critical evaluation. It seemed apparent that if a more prompt disposition of these patients with infected abortion could be accomplished consistent with safety and good practice, the overburdened wards could be lightened and attention directed to more diversified gynecological problems.

In a study of 105 patients with septic abortion admitted to Boston City Hospital in 1955 and 1956, curettage was done in most cases following 12 hours of intensive treatment with antibiotics. The average hospital stay was 5 days. Where curettage was delayed, infection generally spread. Curettage of the septic uterus was the basic treatment.¹ Pathological examination has shown the focus of infection to be the membranes and placenta. As long as these are retained, they continue to feed bacteria to the uterus and blood stream. The early removal of these infected products may be likened to the surgical drainage of an abscess cavity.

Objections to such a program on our ward service stemmed from those men who re-

The author points out that a more prompt disposition of the patient with an infected abortion is consistent with good practice by the physician and safety for the patient. By the use of the early approach, the hospital stay has been reduced materially, late hemorrhages have become less numerous, and the number of transfusions has been cut in half.

The management includes intensive antibiotic therapy, administration of blood and oxytocics as indicated, and the surgical emptying of the infected uterus without undue delay.

membered too well the pre-antibiotic era and the occasional patient with endometritis who developed a fulminant septicemia following curettage. However, there were also those who remembered patients almost moribund in whom improvement was dramatic after curettage. It seemed to us that with the intensive use of antibiotics and the liberal use of oxytocics, especially in late abortions, the uterus could be prepared for early surgical drainage by curettage.

Policy

Until July, 1958 the acceptable method for handling infected abortions on our ward service may be briefly summarized as follows: 1. Antibiotics, 2. Oxytocics, 3. Transfusions as indicated, 4. Bedrest, and 5. Curettage only after the temperature had been normal for 24 to 48 hours, the white count down to 10,000/cu. mm. or below, and unless strong doubt as to the presence of retained products was entertained. Those patients with a definite history or physical evidence of criminal abortion indicating probable uterine perforation were not generally subjected to curettage.

Beginning in July, 1958 the above plan was modified in the following manner: curettage was delayed only until antibiotics had been administered for 12 to 24 hours, without regard to the temperature or the white count, and with delay beyond this time only unless

the hemoglobin was inadequate for anesthesia or unless clinical evidence of uterine perforation existed. Abortions were considered to be incomplete unless they were 14 weeks or beyond, in which case they were individualized.

Material

All patients admitted to the ward service with the diagnosis of abortion were studied for one year prior to and one year following the change in management. Thus we have Group I, consisting of 159 patients, of which 46 (or 29%) were considered to be infected, and Group II, consisting of 166 patients, of which 50 (33%) were infected. Only the infected patients were studied in detail. The diagnosis of infected abortion rested on the presence of (1) fever, (2) a tender uterus, and (3) a foul uterine discharge. All three of these factors were present in all cases studied. The presence of parametritis and pelvic peritonitis was noted when encountered, but was not essential for the diagnosis.

That these two groups are similar and thus suitable for comparison may be shown by the following table.

TABLE 1

	GROUP I		GROUP II	
	Range	Average	Range	Average
Age	14-39	21	13-44	24
Gestation	6-20	10	6-20	12
Gravidity	1-11	5	1-15	5
Parity	0-8	3	0-12	3.5
Temp. on adm.	99-104	101.2	99.4-105.4	101.6
WBC on adm.	6400-47,500	15,000	6000-46,900	14,500
Hgb. on adm.	4.75-13	9.1	4.5-13	9.9

Twenty-one of those in Group I and 17 in Group II had hemoglobin values of less than 10 grams on admission. The range in both groups was 4.5 grams to 13 grams. The range in white blood count was 5,500/cu. mm. to 47,000 in both groups, and the temperature on admission ranged from 99.4 to 105 degrees in both groups.

Results: Group I

In Group I, 36 patients were subjected to curettage and 10 were not. Of the 10 not having curettage, one was criminal with probable perforation, one had septic shock from *E. coli* bacteremia, six were late abortions thought to be complete, and two had hemoglobin levels not brought up adequately for anesthesia, and

were finally discharged. The time from admission to dilatation and curettage in the 36 patients curetted was from 1 to 13 days, averaging 4.5 days. The time from operation to discharge was 1 to 9 days averaging 1.4 days. The average number of days in the hospital per patient for those curetted was 6.6 days, and was 5.3 days for those who were not. Twenty-nine patients received 65 pints of blood for an average of 1120 ml. Twelve patients had a prolonged febrile course from 2 to 5 days after admission. Ten of these came to operation, and of this number, 4 had post-operative temperature elevations.

One patient in Group I bled into shock on the 5th day in the hospital and was finally curetted on the seventh hospital day. One patient had seven days delay because of an elevated white count, and she required 1000 ml. of blood during this time. Another had shock from blood loss on the 10th hospital day necessitating immediate curettage. When curettage was done on the patients in Group I, recovery was usually prompt and no complications of curettage were observed other

than the 4 cases with post-operative fever for 24 to 48 hours.

Results: Group II

In Group II, 41 women were subjected to curettage and 9 were not. Of the nine, eight were late abortions completed spontaneously, with the aid of oxytocics, and the ninth was a criminal abortion with probable uterine perforation. The time from admission to operation was one-half to six days; the average was 1.5 days. (The one patient who was delayed until the sixth day was admitted as an infected *threatened* abortion.) The average time from curettage to discharge was 1.6 days. (One patient was kept 4 days after curettage. She was admitted with septic shock

from *Aerobacter aerogenes* bacteremia.) The average stay in the hospital for those eurented was 4 days, and was 4.5 days for those who were not. Thirty-four of the 41 patients eurented had benign post-operative courses. Seven patients had 24-48 hours of mild to moderate continued temperature elevation. One of these was readmitted one week post-operatively with endometritis. She responded readily to antibiotic therapy.

This was the only readmission in either group and represents the only significant complication attributable to the aggressive policy of early curettage. Eighteen patients in this group received 33 pints of blood, for an average of 900 ml.

Comment

From the foregoing, it seems that the original goal has been achieved; that is, a more prompt disposition of the patient with an infected abortion consistent with good practice by the physician and safety for the patient. The average hospital stay has been reduced from 6.6 days to 4 days. The number of late hemorrhages has been reduced and the total number of transfusions required reduced by half. There have been no really significant

complications attributable to the early aggressive approach to the problem of the infected abortion.

Summary

A two year study of infected abortions has been carried out at the Medical Center Hospitals. The patients admitted consecutively for the year preceding July 1, 1958 with the diagnosis of infected abortion and treated conservatively have been compared with the patients admitted consecutively for one year beginning July 1, 1958 and treated aggressively. The results indicate that those patients treated from July 1, 1958 through June 30, 1959 have fared as well, or better, than those treated the preceding year. Valuable time has been saved and the ward beds made available for more diversified gynecological problems.

The management is essentially one of (1) intensive antibiotic therapy (usually penicillin and streptomycin) for 12 to 24 hours, (2) blood and oxytocics as indicated, and (3) surgical emptying of the infected uterus without undue delay. The majority of our patients thus treated can be discharged within 24 hours and follow-up has shown no significant complications attributed to such a program.

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CHORIOADENOMA DESTRUENS OF UTERUS SPONTANEOUS REGRESSION OF PULMONARY AND PELVIC METASTASES

A CASE REPORT

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A married, white, female, age 28, was first seen in December 1957 complaining of pain in the left lower side with onset early that same day. The patient stated that she had been married 8 years with no pregnancies. Her last menstrual period was in October and at the time of admission she was about 2 weeks

over her regular period. She gave a history of usual regular periods and she had spotted off and on for two weeks prior to admission. She had rather bright bleeding the day of admission.

On admission the cervix was closed, there was a small amount of bleeding from the cervix, the uterus

was anterior and seemed enlarged to the size of a 5 or 6 weeks pregnancy. The cul-de-sac was normal to palpation, there was no pain with cervical motion. The left adnexa were somewhat tender but no masses were definitely palpated. It was thought at this time that the patient had a uterine pregnancy with threatened abortion, and the possibility of a left tubal pregnancy. Some bleeding continued for the next 2 or 3 days but the pain was less. The frog test was positive for pregnancy. She was discharged on the 6th of December after 3 days in the hospital on ascorbic acid 100 mg. twice a day and diethylstilbestrol 5 mg. twice a day. On the 6th of January 1958 a survey film of the abdomen for fetal parts showed a soft tissue mass arising out of the pelvis, somewhat asymmetrical and lobulated. The diameter of the mass measured 20 cm. and the verticle diameter roughly 20 cm. No definite fetal parts could be demonstrated on this film.

The patient was readmitted to the hospital on January 14, 1958 because of continued bleeding, and because of the rapid growth a hydatidiform mole was suspected. On this admission her hemoglobin was 10 grams per 100 ml. (69%). The cervix was 1 cm. dilated and moderate bleeding continued. On this admission several attempts were made with a pit drip to empty the uterus without success. On January 15, 1958 evacuation of the uterus was carried out under anesthesia and the gross findings at this time at surgery were; a uterus the size of a 5 month's gestation, the cervix dilated 1 cm. The cervix was dilated without difficulty with Hegar dilators, the endometrial cavity explored with placental forceps with removal of a large amount of grape-like material. This had the gross appearance of a hydatidiform mole. After removal with placental forceps the uterus was gently curetted with a large blunt curette. There was considerable bleeding present and a 2 inch uterine pack was inserted. The patient received 1000 ml. of blood.

The pathological report on this was hydatidiform mole—Hertig grade III. At that time no evidence of malignancy could be demonstrated. The patient was discharged on the 19th of January after 5 days of hospitalization. She was seen in the office on the 2nd of February 1958, 2 weeks post-operative. There was no bleeding at this time; the uterus seemed normal size but retroverted. The right ovary was of normal size but the left ovary was anterior to the uterus and about 3 times normal.

On March 3rd the frog test was still positive for pregnancy.

On March 21, 1958 the frog test was still positive and repetition of curettage was planned. The patient was readmitted to the hospital on March 23, 1958 for operation because of the positive frog test. At this time she still had had no menses and no unusual leukorrhea.

On this admission the uterus was anterior and felt slightly enlarged but firm. The left ovary was still thought to be enlarged to twice its normal size. At

operation on the 22nd of March 1958 the uterus was slightly enlarged, and sounded to the depth of 4 inches; there was no gross molar tissue present but there was a small amount of endometrial tissue. Pathological report at this time was "persistent trophoblastic tissue following hydatidiform mole." The patient had a fever up to 103° F. on the 2nd postoperative days; this returned to normal after 24 hours.

She was readmitted to the hospital April 9, 1958 with the history of having high fever for several days at home and being treated with antibiotics by her family physician. She complained of chills and fever and of low backache and pain in the left lower quadrant and down the inner aspect of her left leg. At that time there was no bleeding, the cervix was clean, the vaginal vault was clean, the uterus could not be outlined but it was thought to be retroverted. There was a definite tender mass in the left adnexa which was stony hard and estimated to be 3 x 3 cm. The patient was placed on an antibiotic, (erythromycin 500 mg. q. i. d.) Temperature on admission was 102° F. and it stayed between 102 and 103 for 4 days following admission. On the 12th of April an x-ray examination was made for the first time. It was the conclusion at that time there was a great deal of abnormal density in the lungs highly indicative of metastatic disease and the radiologist considered chorioepithelioma. Hemoglobin on this admission was 9.9 grams. The patient had no cough and no respiratory symptoms. After transfusions the patient was taken to surgery on the 12th of April, total hysterectomy and bilateral salpingo-oophorectomy were done. The uterus showed a large bluish area of probable tumor on the posterior wall in the region of the left uterine vessels. There was also separate from the uterus a large nodular mass extensive in the region of the bladder and extending out to the pelvic wall. The ovaries and tubes were grossly normal. At surgery it was impossible to remove all the implants under the bladder and on the lateral pelvic wall. The patient's temperature returned to normal the day following surgery and remained normal for the rest of the hospital stay.

It was the pathologist's impression that there was a malignant hydatidiform mole (chorioadenoma destruens). On April 29, a repeat frog test was obtained and it was still positive.

On the 12th of June 1958 the patient's weight was 109 lbs., her hemoglobin was 13 grams, she had no pulmonary symptoms, her lungs were clear to auscultation, the left adnexal lesion was smaller at this visit and there was no pain but the mass could still be detected at this time. Her last surgery had been 2½ months previously.

On the 20th of June her frog test was still positive.

On her return visit on the 2nd of August 1958 her weight was 115 lbs., her hemoglobin was 13.8 grams but she had noticed some pain in the lower left side. On pelvic examination no pathology could be demonstrated by palpation. Her vaginal vault was clean. A chest film on the 16th of August showed a very ill

defined nodule projected at the level of the left 3rd anterior rib. Tiny fibrotic scars were seen in the lung but the multiple nodular lesions seen in April were gone for the large part. It was the radiologist's impression that the chest showed amazing improvement in view of the past history.

The patient was feeling well and had returned to work. In April 1959 the chest continued to be essentially negative, there was no evidence of any infiltration in the lung, nor any metastatic nodules. All the nodules previously present had completely disappeared without scarring and even the small ill defined nodule in the left lung present on August 16, 1958 had completely disappeared. The lungs were clear and negative. The heart was normal, as was the pleura. In April of 1959, the two male frog tests were negative and a female frog was also negative for the first time.

Summary

This case represents a chorioadenoma des-

truens of the uterus and pelvis following hydatidiform mole. A period of 3 months elapsed from the time of the evacuation of the mole from the uterus until the time of hysterectomy and bilateral salpingo-oophorectomy. Pre-operative febrile course is impressive. This case further demonstrated by films the metastatic spread of this lesion to the lungs with spontaneous regression. It is noted that the primary treatment here was surgery with no chemical or x-ray therapy to the pelvis or to the pulmonary lesions. This patient has had 18 months follow-up, she has gained weight and returned to work and is apparently free of any disease at the present time.

CARCINOMA OF CORPUS UTERI

ROWLAND F. ZEIGLER, M.D., F.A.C.S.

FLORENCE, S. C.

This 10 year review of malignant growths of the uterine corpus, personally treated, is an admittedly small series, but it may have statistical significance as it fits into the general pattern of previously reported larger series. A total number of 18 cases were seen and treated, comprised of:

- 15 adenocarcinoma
- 1 adenoacanthoma
- 1 malignant teratoma
- 1 leiomyosarcoma

The sarcoma was found in an orange sized leiomyoma removed from the lower uterine segment of a 43 year old primigravida at cesarean section.

- Oldest patient 72 years
- Youngest 42 years
- Postmenopausal 12
- Pre or menopausal 6
- Multipara 15
- Nullipara 3

Clinical Stage

- 2-stage 0
- 3-stage I
- 10-stage II
- 3-stage III

There is confusion in estimating the stages of malignant tumors of the uterine body. In this series, stage 0 was considered preinvasive, stage I confined to the endometrium, stage II invading the myometrium, and stage III invasion to the outer third of the myometrium.

A review of eighteen cases of carcinoma of the body of the uterus is offered from his personal experience by the author. Diagnosis, treatment, and end results are discussed and the advantages of radiation and radical surgery are considered. Early diagnosis and prompt surgical excision of the involved uterus are the essentials for successful treatment. The preoperative use of radium appears to be superfluous.

Complications

- 14—grossly overweight
- 13—hypertensive cardio-vascular disease
- 1—diabetes mellitus
- 7—concurrent fibromyomata
- 2—uterine prolapse
- 1—bilateral hydrosalpinx
- 1—previous nephrectomy

Diagnosis

- 16—abnormal bleeding (hypermenorrhea, polymenorrhea or post-menopausal bleeding)
- 10—diagnostic curettage
- 8—enlarged uterus

Enlargement of the uterus becomes an unimportant diagnostic sign for early diagnosis of carcinoma of the fundus, especially with the frequency of associated fibroids. Three patients in this series had negative Papanicolaou smears reported within 3 to 8 weeks prior to positive diagnosis of malignancy.

Treatment

- 17—abdominal panhysterectomy
- 1—vaginal hysterectomy
- 12—postoperative deep X-ray therapy
- 1—preoperative radium insertion
- (2—previous radiation therapy for menorrhagia
- 1—previous radium therapy for carcinoma of cervix)

In the patient treated by vaginal hysterectomy, carcinoma of the fundus was an incidental finding. She was being treated for uterine prolapse. The one patient who had preoperative radium insertion into the uterus had a blood pressure of 250/140 mm. Hg. and a markedly enlarged heart with blowing systolic murmurs. She was being treated for menorrhagia by curettage and 1400 mg. hrs. of radium. However, when the curettings were reported malignant, hysterectomy was done six weeks later.

Results

- 1 patient—stage III, grade III, radiation postoperative, died of metastases at age 63, 4½ yrs. after treatment.
- 1 patient—stage II, malignant teratoma, died cause unknown, age 75, 3½ yrs. after treatment. When last seen 2½ yrs. postoperative, there was no sign of pelvic recurrence, but she was being treated for basal cell carcinoma of lip.
- 1 patient—stage III, radiation postoperative, had an early vault recurrence of carcinoma. (This patient had been urged to have hysterectomy 5 yrs. previously.)
- 15 patients—living and well, no evidence of recurrence. 10 of these patients are now 5 yrs. or more postoperative.

Discussion

Preoperative Radium?

Preoperative radiation has long been used, much has been written about it, and although logical arguments are advanced in its favor, results from its use appear no better than from surgery alone. Patients having had intracavitary radium therapy have residual cancer about half the time. Postponement of surgery for 6 to 8 weeks to allow preoperative radiation is precious time lost. It may take years, however, for gynecological surgeons to repudiate the indoctrination by those long in authority who prefer preoperative insertion of radium, and to adopt primary hysterectomy as the treatment of choice.

Postoperative Radiation?

Many investigators feel that postoperative deep x-ray therapy should be used if there is any question of extrauterine extension, or if the tumor cells are highly anaplastic, but when

metastases are beyond the uterus it is obviously of little or no value. Localized treatment is no good for generalized spread, and patients die of metastases, not of local recurrences. When nodes are positive the end results are consistently poor. The situation is very much the same as in cancer of the breast when more than one node is positive.

Radical Surgery?

Few gynecologists today do radical hysterectomy and node dissection for carcinoma of the uterus. The reasons for this are that the operation is by no means simple or atraumatic, especially in this age group where most patients are already poor surgical risks, and the salvage rate is insufficient to warrant routine lymphadenectomy in this disease. Even in the hands of men like Schwartz and Brunschwig¹ at New York Memorial Hospital, where lymphnode dissections were done in 96 patients, they reported that only 3 of 13 patients who had node involvement survived from 2 to 5 years.

Prognosis

Many clinical and pathological factors are known to affect the ultimate prognosis of endometrial cancer, but the most important single factor is the age of the lesion. This cancer has a long latent period during which the growth is limited to the uterus and the prognosis is good. Prompt adequate surgery produces a survival rate of 70 to 85%, which is the highest cure rate for any internal organ cancer. Once the lesion has extended beyond the uterus, even extended methods of surgical and radiation therapy are often of little or no avail. It is doubtful if radiation therapy preoperatively or postoperatively alters the prognosis of uterine carcinoma.

Summary

1. Endometrial cancer occurs about twice as often after the menopause as before it.
2. The triad of metabolic diseases—obesity, hypertension and diabetes mellitus, often characterizes the menopausal or postmenopausal woman with endometrial cancer, but not necessarily the younger patients with the earlier lesions.
3. For early diagnosis we must not ignore or assume causes of abnormal uterine bleeding, but must investigate promptly. We must not forsake the curette for the swab, as was urged by the late Dr. Emil Novak.

Conclusions

Most recent studies now suggest that early diagnosis and prompt surgical excision of the involved uterus is the common denominator in successful therapy of carcinoma of the corpus uteri, and that the use of radium pre-

operatively is superfluous in the management of operable patients.

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AN UNUSUALLY COMPLICATED VAGINAL HYSTERECTOMY

(TYPHOID FEVER AFTER HYSTERECTOMY)

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SUMTER, S. C.

Adequate pre-operative evaluation and preparation has markedly increased the margin of safety with all elective surgery. Morbidity and mortality associated with hysterectomy has been further lowered since the introduction of the antimicrobial drugs. Pratt and Scherman¹ were able to reduce morbidity following vaginal hysterectomy and repair to 19.8%. Watts and Kimbrough² report 19.9% morbidity in a combined study of hysterectomy.

The failure to recognize the prodromal symptoms of a serious illness in the pre-operative evaluation of a patient recently operated upon, prompts us to report the following case:

R.L.J., colored female, age 28, gravida X, para VIII, aborta 1, was referred to us during her tenth pregnancy, with the request that a sterilizing operation be done after delivery. Examination revealed marked relaxation of the vaginal outlet, cervicitis, and extensive varicosities of the legs. Her history suggested prolapse, though examination at twenty-four weeks gestation did not demonstrate prolapse. It was recommended to the referring physician that the operation be delayed until after delivery and involution of the uterus.

Examination at eight weeks postpartum, showed marked relaxation of the outlet, large cystocele, large rectocele, second degree prolapse of the uterus, and a grade two cervicitis. Papanicolaou smears were negative for malignancy. Vaginal hysterectomy and repair was recommended. When examined the day prior to surgery, the patient appeared in good condition. History revealed that she had had three loose stools two days previous, and two loose stools one day previous. She had had no stool the day before surgery. There was moderate malaise, but no fever. The white blood count was 5,100/cu. mm., with a normal differ-

ential. It was thought that the patient was recovered from gastro-enteritis. On July 11, 1959, vaginal hysterectomy was done, using a modification of the Heaney technique. Anterior and posterior repair was done. Anesthesia was cyclopropane, ether, and oxygen. The procedure went quite well, being completed in one hour and twenty minutes. Blood loss was minimal, thanks to the pre-operative injection of the cervix with procaine and ephinephrin. No blood was given during surgery. The patient's temperature was elevated to 101° F. the afternoon of surgery. She was quite ill the first post-operative day with a temperature of 103° F., malaise, generalized abdominal pain and nausea. The second post-operative day, the temperature was 105° F. She was moderately distended and the abdomen was quiet.

The next 14 days were quite hectic, with daily temperature spikes to 104 to 105° F. Signs and symptoms were those of fulminating peritonitis, with extreme abdominal distention. Constant gastric suction was maintained with the Levine tube. Intravenous alimentation was used. Electrolyte balance was checked with frequent determination of CO₂ combining power, serum sodium, serum potassium, and chloride determinations. Penicillin, streptomycin, and intramuscular tetracycline were given. Blood cultures were negative. The hemoglobin dropped gradually from 13.0 grams to 10 grams. Blood was given on three occasions.

By the seventeenth post-operative day, an abscess was localized in the right mid-abdomen with fluctuation in the right lower quadrant. This abscess was not within reach of the pelvis. It was drained through a right lower quadrant incision. The patient then improved rather rapidly, the bowel function was re-established, but she continued to have daily temperature elevations to 101° F.

On the twenty-first post-operative day, she asked if she might visit two of her children who were patients on the next floor. When we inquired the nature of their illness, we learned that the diagnosis of typhoid fever had just been made. Agglutinations were

then done and were positive for Typhoid H to 1:80 and Typhoid O to 1:160. Stool cultures were positive for *Salmonella typhosa*. The patient was afebrile and symptomatically recovered after five days therapy with chloramphenicol.

We now believe that this patient was incubating typhoid fever at the time of surgery. It is probable that she ruptured a Peyer's patch on the first or second post-operative day, causing the generalized peritonitis.

The literature contained much regarding typhoid as it could complicate obstetrical and gynecological practice up to 1925. Our two leading American obstetrical and gynecological journals have been reviewed for the past ten years and only two references are found which mention typhoid. Alimurung and Monahan³ report a case of typhoid complicating a

five months pregnancy, which was treated with chloramphenicol and recovered. Buchman⁴ reports a case of typhoid ulceration of the vulva in a twelve year old child. This case is presented to remind us that any unusual symptoms should be thoroughly investigated prior to elective surgery.

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POST-OPERATIVE ADRENOCORTICAL FAILURE

A CASE REPORT

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COLUMBIA, S. C.

Since the advent of the widespread use of cortisone and ACTH therapy, a new problem has been presented to plague the surgeon—the management of the patient who has received adrenocortical hormones.

The purpose of this paper is to call to the attention of the physician the fact that prolonged administration of large doses of corticosteroids is not the only condition in producing adrenocortical insufficiency.

We are familiar with the fact that sufficient dosage, if given long enough, consistently induces adrenal atrophy and suppresses pituitary and adrenocortical function. Less familiar, perhaps, is the fact that adrenocortical and pituitary function may remain impaired for sometime after corticotropin has been administered. This period of impairment may be as long as six months. If, during this time, the patient experiences stress of any kind, but in particular, surgery, the pituitary-adrenal system may be unable to cope with the situation. Therefore, the signs and symptoms of adrenocortical insufficiency will develop.⁶

Case Presentation

The case for presentation is that of a 49 year old,

A case of postoperative adrenocortical failure is presented in detail. The action of the adrenal hormones is discussed and an outline is given for the management of the patient who might be subject to this disorder. The recent literature is listed in detail.

colored female, who was admitted to the Columbia Hospital on July 27, 1959, for a hysterectomy because of metrorrhagia and uterine fibroids. The patient had had two curretments prior to this admission. She gave a history of hypertension of unknown duration with intermittent treatment. No other significant past history was elicited with the notable exception of symptoms of rheumatoid arthritis, and treatment with cortisone. The amount of cortisone was considered negligible by the family physician, and the patient was unable to give any accurate history regarding the type of cortisone therapy she had received.

The physical examination at time of admission revealed a moderately obese colored female whose general physical findings were within normal limits with the exception of mild cardiomegaly, and a blood pressure of 200/150 mm. Hg. The pelvic examination revealed a hypertrophied, clean cervix; and the uterus was 2½ times the normal size. The adnexa were normal.

The urinalysis on admission was within normal limits, hemoglobin was 10.8 grams per 100 ml. with a normal white count and differential.

On July 28, the patient underwent a total abdominal hysterectomy under spinal and general anesthesia. The estimated blood loss was approximately 500 to 700 ml. and she was given 500 ml. of blood during the procedure.

The patient exhibited no signs of distress during the surgery or in the immediate post-operative period. The first post-operative day was uneventful, aside from a temperature spike to 101° F. in the afternoon. The physical findings at that time were negative. During the first 24 hours post-operatively, the urine output was in excess of 1500 ml. and the intake was 2000 ml. intravenously. On the second post-operative day, the patient had a temperature of 100° in the morning. Physical findings were normal, and the patient had no complaints. She received 1000 ml. dextrose in water and 500 ml. 5% dextrose in normal saline by 1 P. M. At 2 P. M. or approximately 48 hours post-operatively, the patient was noted by the nurse to be having chills. She was irrational and required restraint. Her temperature in the axilla was 104°, her blood pressure dropped to 90/50. She was perspiring profusely, with a pulse rate of 120-130 per minute. There was no evidence of external or internal bleeding. Blood studies at this time showed blood urea nitrogen to be 17.5 mg. sodium 133 mEq., potassium 3.1 mEq., chloride 94.2 mEq., and a negative blood culture. Blood sugar and CO₂ were not reported; urinalysis was negative.

She was placed in the Trendelenburg position, and intravenous infusion of 5% dextrose in water was begun. She was given Vasoxyl HCl. (methoxamine-HCl.) and Sparine (promazine-HCl.) the latter to control the excitement of the patient. Approximately 30 to 45 minutes after the onset of this episode, 500 ml. of whole blood with 100 mg. of hydrocortisone was begun. A response with mental clarity and blood pressure improvement was noticed almost immediately. She rapidly became fully alert and rational, with a temperature of 99°, blood pressure of 150/90 and pulse rate of 100. At this time, an electrolyte solution (Travert #1), containing 100 mg. hydrocortisone and 500 mg. oxytetracycline was begun. The urine output for 8 hours following the episode of shock was 600 ml. Eighteen hours after the episode, the patient received 100 mg. cortisone intramuscularly and was then begun on cortisone orally, 25 mg. twice daily which she received for 8 days, and it was then discontinued. The remainder of the patient's post-operative hospital stay was uneventful.

Following the episode of shock, upon investigating the patient's therapy with cortisone, it was found from old records of the referring physician that she was first started on cortisone therapy in the form of intra-articular hydrocortisone, 25 mg. in both knees four times from February to March, 1958. She again received oral cortisone four mg. four times daily for four days, and 4 mg. twice daily for 10 days in May

of 1958. In June of the same year, the patient was put on Aristocort (triamcinolone) which she took in "two dollar amounts," that is, she would buy 6 to 8 tablets when she had symptoms and take until they subsided. The patient denied having taken any cortisone for 3 weeks prior to admission.

A review of the physiology of the pituitary-adrenal system reveals that ACTH or cortisone therapy causes an increase in glycocorticoid levels. This increase is induced by cortisone directly, and is produced by adrenal stimulation with ACTH therapy. An increased level of glycocorticoids inhibits the output of endogenous ACTH by the anterior pituitary. Prolonged therapy with cortisone leads to marked hypoplasia of the adrenal cortex. On the other hand, however, prolonged ACTH therapy produces only slight, if any, decrease in the size and function of the adrenals. The exogenous ACTH more than compensates for the decreased pituitary output of ACTH. Thus the insufficiency is felt to be due to a failure of the hypoplastic adrenals to respond to increased ACTH from the pituitary, rather than the inability of the pituitary to produce ACTH.

The action of these adrenal hormones is fourfold:

1. The maintenance and control of electrolyte metabolism. This is accomplished by equalizing the excretion of sodium with the patient's variable intake. The hormones facilitate sodium reabsorption from the renal tubular fluid. The hormones, also, control the amount of sodium excreted in sweat, saliva, and feces. This osmolaric change controlled by sodium, therefore, varies water balance.
2. Control of vascular responsiveness. In the absence of adequate cortical hormones, vessels fail to constrict with repeated administration of ephedrine or norepinephrine.
3. Relation to intermediary metabolism. A lack of cortical hormones creates the inability to convert stored proteins into carbohydrates. An increase in the storage of body proteins is also evidenced. This effect is the one that causes the surgeon the most concern and hesitancy in using corticosteroids with a patient suspected of insufficiency. This concern is not wholly justified. It has been shown that irrespective of the amount of hydrocortisone given in a 30 minute period, 75 percent of the material or its breakdown products can be

demonstrated in the urine or stool within 24 hours. Thus, even when excessive amounts of hydrocortisone are given, this rapid excretion prevents any deleterious effects in the post-operative period.⁸

4. The inability to stand stress. This is probably the most important action of these hormones as far as we are concerned today. This lack of adrenocortical function is manifested by symptoms related to the first three actions just mentioned.

The pathologic changes which occur in a patient who has had cortisone are grossly, a decrease in the weight of the gland, associated with pallor, and a narrowing of the cortex. Microscopic examination reveals a loss of cellular lipid content in both the zona glomerulosa and in the zona fasciculata. This loss is replaced by eosinophilic granular cytoplasm. An examination of the adrenals, weeks, even months, after therapy has been discontinued will show a return of the lipid content and a disappearance of the eosinophilic granulation. There is microscopic evidence that atrophic changes can occur after just five days of cortisone therapy. Thus, theoretically, any dose equalling or exceeding the daily physiological requirements of adrenocortical hormones may suppress adrenal endogenous function. Therefore, the physician should not be lulled into a false sense of security on the basis that the hormone use was of minimal dosage or was for a short period of time. And, as has been presented in our case study, the period of time elapsing since the hormone was discontinued cannot be used as a measure for the need of pre- and post-operative cortisone supportive therapy.²⁰

One case reviewed was that of a patient who died in acute adrenal insufficiency following removal of a bunion. This patient had been on oral cortisone therapy until 4½ months prior to surgery and had received on injection of intra-articular hydrocortisone 15 days prior to surgery. Another patient had received 1.9 grams of cortisone over a period of a month, but received no cortisone for 18 hours prior to 5 minutes of anesthesia for manipulation of a stiff arthritic knee. Twelve hours following surgery, the patient developed shock which responded to intravenous hydrocortisone.⁶

In order to forestall any difficulties, most writers recommend testing the function of the adrenal cortex pre-operatively. This can be done by 17-ketosteroid determination which will show a decrease in the patients with hypo-functioning glands. Another method is the water-loading test of Robinson, Power, and Kepler in which the fasting patient is given 20 ml. of water per kilogram of body weight in a 30 minute period. The normal patient will excrete 70 to 90 per cent within 4 hours. The patient with decreased cortical function will usually excrete less than 50 per cent in 4 hours. However, positive results have been gotten in cases of malnutrition and alcoholism. Probably the most popular test is the Thorn Test. In this, the normal response of a normal gland is a decreased total eosinophilic count following administration of ACTH.

If shock from adrenocortical insufficiency occurs, or if it is suspected of occurring, a test of Perlmutter at Brooklyn, N. Y., is reported. This test can corroborate clinical impressions one hour after seeing the patient. It is done by simultaneous determination of serum and urine sodium concentration. If a deficiency of adrenal corticosteroids is present, the renal tubules are unable to absorb sodium adequately, so there is a persistent urinary salt loss despite hyponatremia. This test is also positive in patients with renal tubular damage, as in salt-losing nephritis.¹⁸

However, there is a simpler method of testing which will add strength to the clinical post-operative impression of adrenocortical insufficiency. It is the determination of the total eosinophilic count. Normally, following surgery (or stress) there is a decrease in eosinophils for 24 to 48 hours. Therefore, with the presence of 50 to 100 eosinophils per cu. mm. of blood within this period, adrenocortical insufficiency should be suspected.¹⁶

The development of adrenocortical insufficiency post-operatively may be sudden or subtle. It has been noted that a hypoadrenal response is seldom evidenced during anesthesia. However, high spinals or deep general anesthesia seem to predispose to hypoadrenal shock post-operatively.

The signs, symptoms, and laboratory findings suggestive of and associated with acute

adrenocortical insufficiency are as follows:

1. Delayed shock unrelated to a depleted blood volume, plus a lack of response to blood replacement.
2. Marked hypotension with tachycardia.
3. Cyanosis of fingers, toes, neck, and face.
4. Profuse sweating with extreme thirst.
5. Marked hyperpyrexia with cold, clammy skin.
6. Mental confusion, followed by disorientation and coma.
7. Pain and tenderness of both kidneys.
8. Oliguria and anuria.
9. Increased NPN and serum potassium.
10. Decreased serum Na. and serum Cl.
11. Occasionally, a low blood sugar is present.
12. No decrease in the total eosinophilic count.
13. Albuminuria is occasionally seen.
14. May be a low CO_2 .
15. And, there is usually an excessive loss of urinary salt.

The consensus of all writers in regard to treatment is: when in doubt, give cortisone. All writers state that the patient on cortisone at the time of surgery should have the dosage increased pre-operatively and for several days post-operatively and maintained for 3 to 5 days. All patients who have ever had cortisone and exhibited hypercortisonism should also be treated pre-and post-operatively. It is also recommended that the patients who have had cortisone prior to a six-months period before surgery, even though they have not exhibited hypercortisonism, should be followed closely for the first 24 to 48 hours post-operatively. This includes hourly recordings of urine output, blood pressure, and temperature. In contrast to the usual fluid therapy, these patients should be given a minimum amount of water. If insufficiency occurs, normal saline, post-operatively, should be administered. It has also been noted that since morphine potentiates the insufficiency, it is recommended that no morphine or its derivatives be used.

The management of the patient who has received corticosteroids within six months prior to surgery, but not currently under treatment is set forth by McMillian, Powell, and Haines.¹⁶ The recommended method is as follows:

1. Cortisone acetate 50-100 mg. intramuscularly the evening prior to surgery.
2. Hydrocortisone, 100 mg. intravenously through the night prior to surgery and repeated following surgery.
3. Cortisone acetate 25-50 mg. once or twice daily thereafter so long as it is felt necessary to avoid insufficiency.¹⁶

A suggested dosage schedule for patients who are receiving cortisone or ACTH at the time of surgery is outlined as follows:

1. For the patient on cortisone therapy, ACTH 20 to 30 units intramuscularly every 6 hours for five days prior to surgery, then an additional 100 mg. of cortisone intramuscularly daily for two days before surgery and the day of surgery. Post-operatively, the patient is given 25 mg. of cortisone intramuscularly every 6 hours for three days, then the pre-operative oral dosage is resumed. Also ACTH is given in 20 units doses every 4 to 6 hours for 2 days, then 15 units every 6 hours for 2 days, then 10 units twice daily for 2 days, then 5 units twice daily for one day.
2. The dosage schedule for a patient on ACTH therapy at the time of surgery is 100 mg. of cortisone intramuscularly daily for 2 days before surgery and the day of surgery, with a continuation of the usual dose of ACTH. Post-operatively, these patients receive 25 mg. of cortisone every 6 hours for 2 days, then 25 mg. every 8 hours for 2 days, 25 mg. every 12 hours for 2 days, and finally 25 mg. daily for 2 days.
3. The patients on ACTH or cortisone therapy who require emergency surgery, are given their usual hormone dose, plus 300 mg. of cortisone intramuscularly and 30-50 ml. of aqueous adrenal cortical extract intravenously during surgery. The post-operative coverage is as outlined in the two previous schedules.¹⁴

Summary

Unexplained shock states post-operatively which fail to respond to vasopressors or adequate blood replacement are most likely due to adrenocortical insufficiency.

It is recommended to suspect and treat patients who have been treated previously with

adrenal hormone bearing in mind the maxim that insufficiency is easier to prevent than to treat.

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MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

Hypercalcemia (Parathyroid adenoma)

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Dept. of Medicine

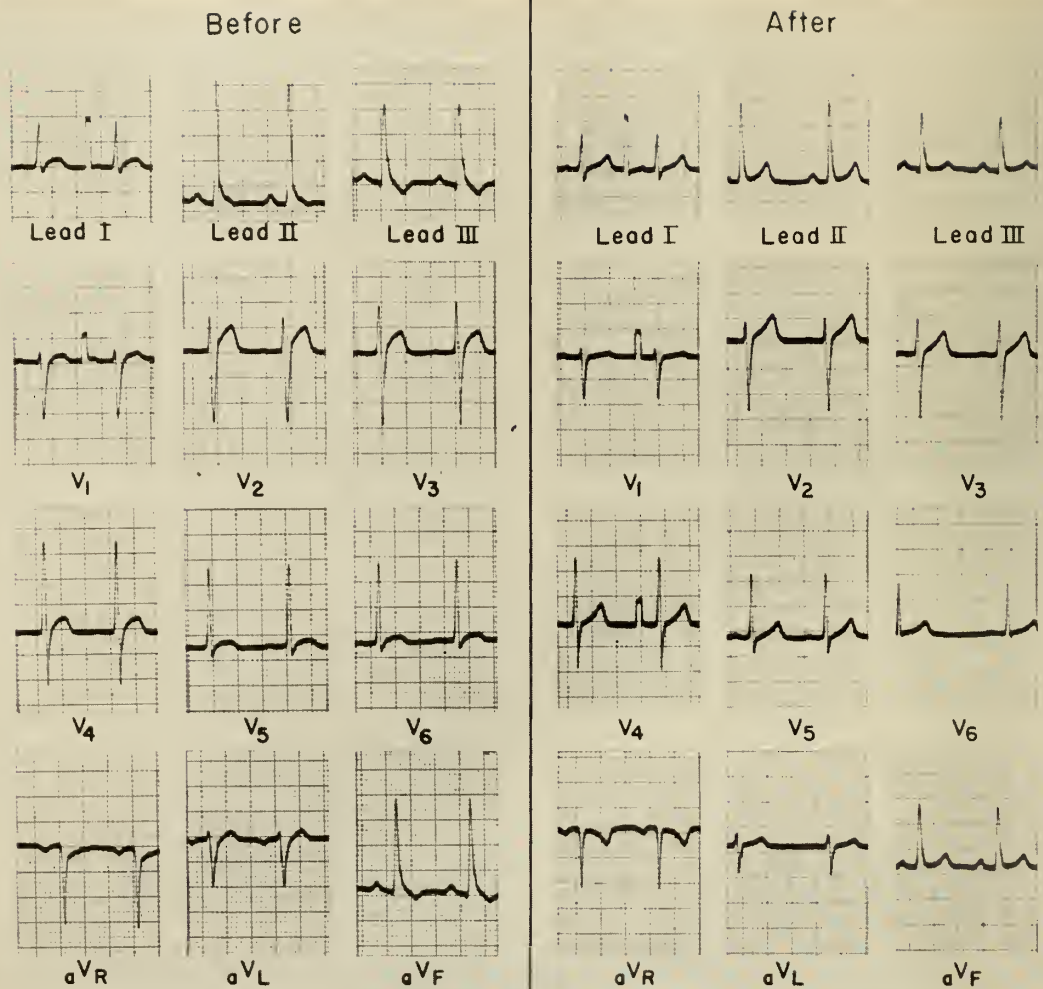
Case Record—The finding of marked wasting and flabbiness of all muscle groups of a 24 year old Negro confirmed his history of progressive weakness. Previously healthy and accustomed to heavy manual labor, he had within three months become unable to work and had lost some 30 pounds in weight despite a good appetite. During the same period of time he had experienced dull aching pain in the spine and bones of the extremities. Other associated symptoms were polydipsia and nocturia, occasional edema of the ankles and intermittent abdominal distress without any specific gastrointestinal dysfunction. Because of painful heels he walked on his toes.

When the electrocardiogram on the left was made the patient's serum calcium was 19.8 mg. per 100 ml. (the phosphorus 3.0 mg., alkaline phosphatase 17.1

King-Armstrong units). The 24-hour urinary excretion of calcium with the patient on a low calcium diet was approximately five times normal—610 mg. Various tests of renal function indicated considerable impairment but the blood urea nitrogen level was normal, as were the total and fractional serum proteins. There was a moderate hypochromic anemia.

Roentgenographic findings were consistent with hyperparathyroidism, showing marked rarefaction of all bones of the skull, spine and extremities. Loss of the lamina dura was evident on the dental films. Possibly on account of the short duration of the disease, no calcification was visible in the kidneys or vascular structures.

At operation a parathyroid adenoma was searched for and found—a 3.5 x 3 x 1.5 cm. nodule having a prominent vascular pedicle and a bluish discoloration, located below and behind the left lobe of the thyroid between the carotid sheath and the prevertebral fascia. Biopsy of a grossly normal parathyroid from the opposite side of the neck showed relative atrophy of glandular epithelium.



The tracing on the right was made one week after operation at which time the calcium level had dropped to 9.9 mg., (phosphorus 2.0 mg., alkaline phosphatase 34.7 mg.) and the urinary calcium excretion to 70 mg. with the patient receiving a high intake of dietary and supplemental calcium. A striking increase in muscle strength and tonus was noted postoperatively.

This young man had no evidence of cardiac disease.

Electrocardiograms—The electrocardiogram on the right is normal and shows only a sinus arrhythmia which, curiously, is not notable in the pre-operative record. The QRS complexes are of somewhat higher amplitude and greater width in all leads (including the precordial leads which are recorded at half sensitivity throughout) before surgery with some apparent slurring or notching in II, III and AVF where the T waves are inverted.

There is a difference of about 0.04 sec. in the Q-T intervals of the two tracings but a more striking

contrast is in the junction between the QRS and T waves: when the calcium level is abnormally elevated there is practically no S-T segment, the T waves appearing to begin prematurely above or below the baseline. Minimal, if any, change takes place in the P waves or P-R intervals.

Discussion—Relatively little has been written about the electrocardiographic signs of hypercalcemia, probably because they are less dramatic, less diagnostic than those of low calcium states. Certainly this case represents an extreme degree of hypercalcemia in a young man with a presumably normal heart and a comparison of his electrocardiograms, made the same month, could be expected to portray the isolated effects of an excessive level of calcium in the blood.

The Q-T interval (more specifically, the length of the S-T segment) is shortened in hypercalcemia in accordance with the known inverse relationship between length of the Q-T and the level of serum calcium. Additionally in this case there are the changes in depolarization potential, in repolarization, and the

suppression of the sinus arrhythmia which can hardly be attributed to anything but action of the calcium ion. It is difficult to say how much of the apparent widening of QRS complexes is due to a prolongation of depolarization and how much to premature beginning of repolarization—both are evident here. Some aberration of ventricular conduction could of course account for both the QRS and T wave alterations. However all these features of the pre-operative ECG are remarkably minor considering the degree of

electrolyte disorder. Knowing the clinical data and the effects of a deficiency of calcium ion one can regard them as significant.

The action of calcium on the heart is similar in some respects to that of digitalis, both electrically and physiologically. While hypercalcemia alone may be tolerated well by the myocardium, the hazard of injecting calcium into a digitalized patient is well recognized.

Studies of assisted circulation of heart failure.

I. Method of Producing Heart Failure in the Dog

Frank J. Veith, M. D., Wendell B. Thrower, M. D., (Charleston) Dwight E. Harken, M. D. and Francis D. Moore, M. D. Surg. Gynec. & Obst. 109:687-690, Dec. 1959.

An experimental animal in heart failure is required to evaluate partial cardio-pulmonary bypass as a means of assisting the failing heart. The Barger technique for creating right-sided congestive failure by the staged production of tricuspid insufficiency and pulmonary artery stenosis is the most thoroughly studied and reliable of the many experimental forms of heart failure. However, the original technique has never been described in detail. In the first six animals operated on by the original technique, there were five deaths due to technical errors. Work was then done on cadavers and several improvements in the original technique evolved. With the improved technique, there has been only one death in the last fourteen animals. All of these developed the typical form of right-sided heart failure. Because the method produces a reliable and well studied form of heart failure, these improvements will be reported in detail. A special tricuspid valvulotome is depicted. A method for assuring complete tricuspid valve destruction is outlined. A new clamp is introduced for safety isolating and stenosing the pulmonary artery.

The use of sodium excretion following a standard saline load as an index of the degree of heart failure before and during assisted circulation is introduced.

II. The Affect of Partial Extracorporeal Bypass on Normal and Heart Failure Dogs

Wendell B. Thrower, M. D., (Charleston) Frank J. Veith, M. D., Stephen Lunzer, M. D., Dwight E. Harken, M. D., and Francis D. Moore, M. D. Surg. Gynec. & Obst. 110:19-26, Jan. 1960.

Recent success of total cardio-pulmonary bypass for open heart surgery has stimulated the interest in methods of partially assisting the failing heart over long periods of time. The lack of an objective index of improvement in evaluating the critically ill patient has led us to look to the animal laboratory for a method.

This project was designed to study the use of the urinary excretion of sodium as an index of the status of heart failure in the dog while on partial bypass with a Kay-Cross disc oxygenator. This index of heart failure has been well studied by Barger and is certainly the best known form of chronic right-sided heart failure.

Ten normal dogs were perfused as controls. The urinary sodium excretion following a standard saline load fell within normal limits in the majority of these animals on bypass.

Heart failure was then created by a modification of the Barger technique in 15 dogs by the combined production of tricuspid insufficiency and pulmonic stenosis. These animals characteristically retained sodium after standard saline load according to a pattern that has been well documented by Barger.

Four of the 15 heart failure animals were partially bypassed from one to three hours duration. The sodium excretion while on partial bypass was the same or less than the excretion during the control run without bypass. Explanations for the discrepancy between the urinary excretion of the normal and heart failure animals are offered.

The majority of the normal animals which were successfully bypassed lived but all of the heart failure animals died shortly following perfusion, with obvious increased congestion of the splanchnic system. This study points out the fact that further animal investigation is indicated before applying partial perfusion in its present form to the heart failure patient.

RHEUMATIC FEVER

William Weston, Jr., M. D.
Columbia, S. C.

It is evident that rheumatic fever in the clinics is discovered comparatively late, i.e., in chronological years. We have twenty active cases in our private practice who are under our treatment, with an average age of 6.7 years, while in the clinic the average age is 14.3 years. This, to me, indicates that we are not seeing or diagnosing our clinic cases sufficiently early.

for the year 1958—

195 cases with percentage of 2.9; and for the year 1959—

129 cases with percentage of 5.2.

Mortality:

Number of deaths reported of rheumatic fever for the year 1958—

105 deaths with percentage of 4.2. These were based on a rate of 100,000 population.

JONES CRITERIA (MODIFIED FOR GUIDANCE IN THE DIAGNOSIS OF RHEUMATIC FEVER*:

Major Criteria:

- (1) Carditis
- (2) Polyarthrititis
- (3) Chorea
- (4) Subcutaneous nodules
- (5) Erythema marginatum

Minor Criteria:

- (1) Fever
- (2) Arthralgia
- (3) Prolonged P-R interval in the ECG
- (4) Increased ESR, WBC, or presence of C-reactive protein
- (5) Preceding beta hemolytic streptococcal infection
- (6) Previous rheumatic fever or inactive rheumatic heart disease

*Bulletin, American Heart Association, 1955, p. 5.

Rheumatic fever is quite prevalent in South Carolina. The morbidity rate and the mortality rate are as follows:

Morbidity:

Number of cases reported of rheumatic fever

This disease is usually preceded by beta hemolytic streptococcus A infection, most often the throat. The heart is usually not involved in the first attack, but frequently in recurrent episodes; therefore, it behooves us to

RHEUMATIC FEVER PRIVATE PATIENTS 21

Major Manifestations

Carditis	21
Polyarthrititis	13
Chorea	1
Subcutaneous nodules	0
Erythema marginatum	1

Minor Manifestations

Frequent URI	17
Fever, recurrent	13
Increased sed. rate	17
Anti S O Titer (increased)	4
Family history of Rheumatic Fever	6

RHEUMATIC FEVER CLINIC CASES 155

Major Manifestations

Carditis	155
Polyarthrititis	91
Chorea	1
Subcutaneous nodules	0
Erythema marginatum	1

Minor Manifestations

Frequent URI and sore throat	25
Fever, recurrent	30
Increased sed. rate	118
Increased A S O titer	23
C Protein Reactive	54

prevent succeeding attacks, which prophylaxis is usually accomplished by using intramuscular injections of benzathine penicillin-G, sufficiently large amount to last four weeks, 600,000 units under 6 years, and 1,200,000 units over 6 years, repeated every four weeks (28 days). Sulfadiazine is sometimes administered per os, 0.5 to 1 Gm., every 24 hours daily to prevent streptococcus infections, but it will not eradicate the streptococcus infection when present.*

For dental extraction or elective surgery we give all-purpose Bicillin, 1,200,000 units intramuscularly three days before and procaine penicillin, 300,000 units, the day of, and 600,000 units of penicillin the day following the operation.

Many cardiac clinics advise the use of a

preventive with benzathine penicillin-G with congenital heart disease, or with siblings who have brothers or sisters with rheumatic fever. The latter is especially noted when parents have history of rheumatic fever in the low socio-economical scale.

Summary and conclusion:

The outline of Rheumatic Fever emergencies with their treatments has been given.

Prevention of recurrent attacks of rheumatic fever is essential. Benzathine penicillin G has proven the most satisfactory drug to control streptococcus infections.

Good housing, proper clothing, and proper food, with sufficient rest, will assist in preventing recurrent attacks of rheumatic fever.

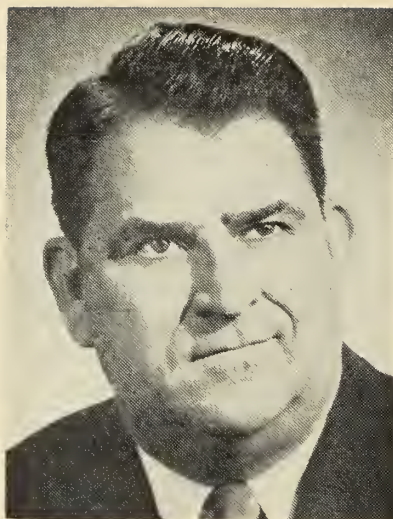
*Gasul, B. M. and Arcilla, R. A.: Prophylaxis and treatment of cardiovascular emergencies in infants and children. JAMA, 172:44, 1960.

RHEUMATIC FEVER EMERGENCIES

I. Fulminating infections with or without proven bacteremia. Original or recurrent exacerbations Bacterial endocarditis	Treatment One million units penicillin every 4 hrs. Steroids
II. Cardiac decompensation Congestive heart failure	Digitalization—Lanoxin, 0.02 to 0.03 mg. per lb. body wt. 1st dose $\frac{1}{2}$ of total, then $\frac{1}{4}$ in 6 hrs. and $\frac{1}{4}$ repeated in 12 hrs., $\frac{1}{10}$ of total dose daily for continued digitalization Oxygen tent Sedation Low sodium intake
III. Pancarditis	Same as above
IV. Cardio-renal complication	Digitalis Diuretic (Mercurhydrin (Diuril (Diamox Fluid Balance
V. Chorea	Sedation-barbiturates Tranquilizers Isolation

The general therapy of rheumatic fever is

- (1) bed rest during acute symptoms and febrile attack
- (2) salicylates $\frac{1}{2}$ gr. to $\frac{3}{4}$ gr. per lb. body wt.
- (3) fluids in abundance
- (4) dietary control with ascorbic acid—proteins—fruits—vegetables—eggs and milk products
- (5) eliminate streptococcal infection



President's Page

ORGANIZATION IN OUR COUNTY SOCIETIES

It should be axiomatic that a unit which is as important to the whole State Medical Association as a county society should have an adequate and well planned organization. Unfortunately, this is not always the case. On many occasions, officials of the State Society have contacted local groups, and have found it very difficult

to pinpoint the person responsible for the problem to be discussed. At times, even the President of the County Medical Society has been unaware that he held this honored position. It is important that the County Medical Society elect officials who will recognize their responsibilities and fulfill them. It is not fair to select a young and inexperienced person to responsible leadership just because it is felt that he will take the job, and has nothing else to do anyway. Likewise, it is not fair to the society or the man, to elect a senior physician to the presidency who will feel that the position is an honorary one without responsibility. It takes a mutual understanding between potential officers and the society itself, as to who are the proper ones for leadership.

In order that county society work might be carried on most efficiently many of our larger counties have organized their membership into committees whose duties it is to consider the problems which come under their particular scope. Committee set-up is followed all the way through organized medicine. The American Medical Association has many Councils and Committees which study varied and sundry subjects relating to medical care. Our State Society also is organized into committees, some of which are similar to those in the American Medical Association, and some which are necessary because of our own peculiar local situations. Of the County Societies in our state some are already set up into committees. Some follow to some extent the standing committees of our State Association. Other committees are varied to meet special needs. It is recommended that every county society, no matter how small, be organized into committees according to their local need and interests.

Most important is an executive committee. The smaller counties can throw all of their problems in this committee if it be desired. However, the main point is to have someone in authority who recognizes it as his responsibility and who has the power to act. If occasion should arise that the South Carolina Medical Association wants to discuss a problem with the County Society or, as often happens in our legislative crises, it becomes necessary to elicit the aid of the County Delegation on a local basis, it is absolutely imperative that someone has been delegated to receive such information and requests. Some of the medium sized counties might also want to consider a committee on emergency care, which could include furnishing 24 hour emergency service for people unable to locate their family doctors, as well as the more complex organization of civil defense and catastrophe emergency plans.

It has been suggested, and we hope that some uniformity might be carried out, that all county officers be elected in December. Even though our Medical Association usually meets in May, the fiscal year of the South Carolina Medical Association and the American Medical Association, runs from January 1st. to December 31st. It is well that the officers, particularly the Secretary and Treasurer whose job it is to collect dues, should not be crossed up between two different officers during the same year. We hope that all counties will take cognizance of this, so that their organization for the coming year can be done during the preceding December.

As indicated in my letter last month, one of the goals for my administration this year is to have a State Association fully informed about the problems of each individual county and have the members of each individual county society informed as to problems and proposals which have been brought up on a state basis. It is hoped that during the coming year this exchange of ideas can be carried out between all counties in the state, and that next May when our delegates meet for their annual deliberation, we will have a House of Delegates better informed than ever before.

Joseph P. Cain

Editorials

MYRTLE BEACH MEETING

The 112th Annual Convention of the Association ran a very successful course at Myrtle Beach on May 17, 18 and 19. There was a good attendance, exceeding 500 physicians, and attention to the scientific program was noticeably better than it has been in past recent years. Social events were pleasant and everything ran very smoothly. The business of the Association was conducted ably by Dr. William Weston, who retired at the end of the Convention and made way for Dr. Joseph P. Cain of Mullins. Dr. B. J. Workman of Woodruff was chosen vice-president, Dr. Robert Wilson was re-elected secretary and Dr. J. Howard Stokes was again named as treasurer.

There was little or no controversial activity in the business sessions. A resolution introduced by the Greenville Society calling on the Federal government to cease entering into new programs and to decline to engage in the various social welfare schemes which had been proposed produced a bit of discussion and was finally passed in an atmosphere of hope rather than expectation of accomplishment.

There was some discussion over the desirability of promoting compulsory immunization of pre-school children against diphtheria, whooping cough, tetanus, and poliomyelitis. The final decision was that legislation should be encouraged, even though there might be some reservation of opinion about the desirability of any compulsory measure in this field.

An arrangement for biennial registration of physicians with the State Board of Medical Examiners was endorsed. This measure had been discussed before and drew some discussion but it was passed without any real obstruction.

The Benevolence Committee which was proposed last year was recommended for implementation by the Reference Committee and Dr. W. A. Smith was elected for a three-

year term, Dr. O. B. Mayer for two years and Dr. Thomas G. Goldsmith for one year as a committee to develop details of the plan. No specific sum of money was appropriated, but Council was instructed to consider something in the neighborhood of \$20,000 if that amount was satisfactory or feasible, or else to determine what funds could be utilized without injury to the general state of the treasury. Dr. Charles N. Wyatt of Greenville was named president-elect, and Dr. J. H. Gressette was elected to fill his place as chairman of Council. Dr. Clay Evatt of Charleston was elected Councillor from the First District, Dr. John P. Booker, Walhalla, from the Fourth District, and Dr. Norman O. Eaddy, Sumter, from the Seventh District.

Members of the Mediation Committee elected were: Drs. Henry Robertson, Charleston, First District; Anthony White, Easley, Fourth District; and S. E. Miller, Georgetown, Seventh District (re-elected). Members of the State Board of Medical Examiners re-elected were Dr. Harold Jervey of Columbia, Dr. Harold S. Gilmore of Nichols. Members of the Hospital Advisory Committee of the State Board of Health: Drs. Roderick Macdonald of Rock Hill, and Dr. B. J. Workman of Woodruff were also re-elected.

Charleston was chosen as the meeting place for next year's convention.

OBSTETRICAL BEDS

With the increasing number of new hospitals, particularly in suburban areas, and in the adjacent smaller towns, some city hospitals have found themselves in the position of having a relatively large number of vacant beds in their obstetrical departments. In some large hospitals an occupancy of 50 to 60 per cent is quite usual. This small use of the available beds produces an economic loss to the institutions.

Many of these hospitals face a crowded situation in other parts of the hospital, and in order to relieve the shortage of beds in these

departments, it has been proposed in several hospitals that it might be possible to use the surplus obstetrical beds for gynecological patients. As a matter of fact, this arrangement has already been established in some hospitals which have surveyed their individual situations and decided that certain types of gynecological patients might safely be cared for in an obstetrical ward.

In order to provide a sound basis for this decision, seven national medical organizations have united to make a survey to determine the advisability and feasibility of carrying out the proposed arrangement. They are the American Academy of General Practice, American Academy of Pediatrics, American Hospital Association, American Public Health Association, the Children's Bureau of the Department of H. E. W., and the Maternal Health Nursing and Statistics Section of the United States Public Health Service. They will be working under a grant from the National Institutes of Health, and it is to be expected and hoped that a reasonable answer to the question will soon be established for guidance in the many instances in which it will be needed.

CHARLES N. WYATT, M. D.
PRESIDENT-ELECT

Charles N. Wyatt, President-elect of the South Carolina Medical Association was born in Easley, South Carolina, January 3, 1904, the son of Charles Newton and Addis Pickens Wyatt. His father and one uncle practiced medicine in Easley for a number of years.

Dr. Wyatt was educated in the public schools of Easley, attended Wofford College for one year and the College of Charleston for two years. He graduated from the Medical College of South Carolina in 1927, and trained at St. Francis Xavier in Charleston and Emma Moss Booth Memorial Hospital in Greenville, S. C. He started practicing medicine in Laurens in November, 1928, later returned to Greenville, August, 1928 in the office of Dr. Hugh Smith. In June, 1928, he married Louise C. Patjens of Mt. Pleasant, S. C., and they have three children. One of them, Louise Wyatt, is a Junior at the Medical College of S. C.



DR. CHARLES N. WYATT
President-elect of the South Carolina Medical Association 1960-1961.

Dr. Wyatt served nearly five years in the Army of the United States in World War II. Entering as a Captain of Medical Corps, June, 1941, he advanced to Colonel, August, 1944. He was Chief of the Medical Service Station, Camp Forrest, Tenn., and commanded Field Hospitals in Iran, Station Hospitals in Iran, Italy and Okinawa. Honorably discharged from service February, 1946, he resumed general practice in Greenville early in 1946 and has been hard at it ever since.

He has served as President of the Greenville County Medical Society, President of the South Carolina Chapter of the American Academy of General Practice, Delegate to the AAGP for ten years, serving on several committees, Alternate Delegate to the American Medical Association, serving as Delegate at the interim session in Minneapolis, December, 1958. Member of the Council South Carolina Medical Association since 1951, he served as Chairman of the Council 1959-60, Chairman Committee of Civil Defense, S. C. M. A. for five years, Member of the Committee on Disaster Medical Care, Council on National

Security of the American Medical Association.

He has been a member of the Lions Club of Greenville for twenty-five years and president in 1948-49. He is a member of the Country Club, Greenville, a 32nd Degree Mason and member of the Ancient Arabic Order of the Mystic Shrine. He is Medical Director of HEJAZ Temple of Shrine, and a member of the Trinity Lutheran Church, Greenville and a member of the Chamber of Commerce of Greenville and the U. S.

At present and for the last fourteen years he has practiced general medicine at 301 East Coffee Street, Greenville, in partnership with Dr. Horace M. Whitworth.



HYPNOTISM REVIVED

Stemming directly from the teachings of Mesmer in the late eighteenth century and a background reaching into antiquity, hypnosis has enjoyed a cycle of alternating popularity and neglect. At the moment it seems to be climbing again to a peak of medical favor and respectability.

Mesmerism enjoyed a great vogue until it was condemned officially by an investigating board which included Benjamin Franklin, and was out of favor until another investigation in 1826 brought a more favorable report, and Poyen, a proselyting Frenchman, created a great interest in its qualities in America. Following this appearance at the crest of the wave it sunk again into the trough and has had its ups and downs ever since, until now it has the modified blessing of the AMA and the encouragement of a number of accepted

courses of instruction in reputable medical schools.

The uninitiated is inclined to wonder whether today's resurgence is only another wave in the cycle, and to question the reasons for former declines. Advocates claim that "there is considerably more psychodynamic understanding of what hypnosis is than was true in the past", and even if this statement is unclear to the medical layman — that is, the non-psychiatrically-oriented medical man — he concedes some correlation with modern psychosomatic concepts and even the more obscure depths of psychiatry.

The technique of hypnotism appears to be simple. Its dangers are well recognized, and it seems unwise for the run-of-the-mill practitioner to attempt anything more than the induction of the lighter stages of hypnosis. Induction of the deep trance should be left to those in psychiatry or those with special training who can un-trance the entranced quickly and effectively if need be.

It would probably surprise the old family doctor to realize that he practiced a great deal of "suggestion therapy" under the guise of the bedside manner and the close relationship between doctor and patient. Perhaps the decline of these approaches in the modern physician may explain some of the current interest in hypnosis and the pleas for extension of its uses. It is reasonably sure that the older physician would have been less likely to transgress the bounds of safety and simplicity in the unconscious use of what can now be a valuable recognized technique, provided its limits are clearly understood.

THE PRESENT STATUS OF THE SOUTH CAROLINA MEDICAL ASSOCIATION AND THE FUTURE OF MEDICINE AS OPPOSED TO SOCIALIZED MEDICINE

WILLIAM WESTON, JR.

South Carolina has a glorious past in Medicine and should have a marvelous future. Worth mentioning are Dr. Hugh Huger Toland, (1806-1880), who established the University of California Medical School, the celebrated Marion Sims, (1813-1883, who

founded the Woman's Hospital in New York City, Dr. Harry Mustard, who did much in Public Health, and Dr. Edwin Samuel Gailard, (1827-1885), who helped to eradicate yellow and malaria fever so that the Panama Canal could be finished.

Even in our own lifetime there prevail some notable medical advances:

- (1) The first *uncinaria americana* (hook-worm) clinic in the world was in Columbia, South Carolina.
- (2) The first description of the pink disease (*acrodynia*) in the New World was by a South Carolinian, and
- (3) The discovery of the iodine-rich soil in our State was made by my distinguished father, Dr. William Weston.

This last named subject, iodine in the soil, should be emphasized and utilized. Our Development Board could popularize this fact so that manufacturing plants galore could and would move into our State.

- (4) Dr. A. T. Moore is world renowned for his successful hip operations.

Our Medical College has grown to great distinction. The research work done there in circulatory disturbances and cardio-vascular operations is internationally recognized.

Our State Board of Health deserves a bouquet for their astute control of water pollution, allowing manufacturing plants to flourish without interfering with the wild life development. The Forestry Department deserves much credit in helping to make South Carolina a great place to work and live. We have an abundance of fruits, vegetables, cattle, wood, game, and fish. Let's help keep it this way for future generations.

Our population is two million four hundred thousand. That means an average of one doctor for every 1,600 individuals. That is just half of what it should be. We must have more doctors in South Carolina.

Medicine deserves credit for its independence and not falling before the ax in this horrible Social Security, that is, in the manner it is set up and run now. We should owe our government a living and not feel that the government should owe us a living. The Mur-

ray-Dingle Bill, the Forand Bill, and a few others have been executed, but believe you me, their demise is temporary and they will rise again. Let's strive to maintain our independence. Your children and grandchildren will appreciate your staunchness in helping to maintain the American Free Enterprise system. Good fair competition creates initiative, while socialism means stalemate and regression.

Hearsay or word of mouth is a poor source of information unless the facts have been substantiated. There are now three cases pending suit against doctors in South Carolina who signed certificates of commitment to the South Carolina State Hospital without making an examination. Gentlemen, this is taking terrible risks. Let's be more astute and careful.

The Aged:

Since the medical profession through science, diet, antibiotics, vitamins, and drugs is largely responsible for the prolongation of life, it is our duty and responsibility to take care of these whose years we have helped to lengthen. We must do this to the best of our ability and without cost to the patients unless their income warrants payment. There are approximately sixteen million people in the United States who are 65 years or older.

Shortening Courses for Doctors:

The M. D.'s had a choice of 60 per cent of those in the top brackets of academic studies previous to 1950. This figure has dropped to 40 per cent. Other professions have more to offer, especially from a remunerative standpoint. Therefore, we must meet the challenge. My suggestions:

- (1) Cut the preparation and medical courses to six years.
- (2) Eliminate interns and have assistant residents and residences.

Civil Defense:

It is important that we must cooperate with the Civil Defense organization. An excellent schematic programme has been gathered—which I have placed on a table along with the maps in the northwest corner of the ballroom. What about a fallout or shelter area? Use your basement or a neighbor's basement.

Woman's Auxiliary:

This portion of our medical association is all important. If you wish something done promptly, then call on our auxiliary. If it is needed, you will find that they will accomplish it quickly. I gladly take my hat off to them.

CORRESPONDENCE

Dear Dr. Waring:

The National Society for the Prevention of Blindness is receiving a number of inquiries regarding the relationship between oxygen therapy for premature infants and retrolental fibroplasia. Specifically, it is asked when the knowledge, that uncontrolled use of oxygen in the treatment of premature infants might result in retrolental fibroplasia, became generally available to the profession and hospitals.

Those who fail to follow recommendations established by competent authority for prescribing oxygen for premature infants subject their patients to the risk of blindness.

The entire medical profession and all hospital administrators have a duty to institute and persistently follow procedures in the administration of oxygen to premature infants that will prevent retrolental fibroplasia.

Enclosed is an annotated bibliography on the relationship of oxygen therapy to retrolental fibroplasia. These references are set out in chronological order to show when it was that knowledge of the cause and prevention of RLF became available to the medical profession.

Your cooperation in forcefully bringing this subject to the attention of your readers will be deeply appreciated by the National Society for the Prevention of Blindness and its Committee on Retrolental Fibroplasia. Many others who have either a professional or personal interest in the universal use of such important sight saving information will be equally appreciative.

Thank you for your assistance.

Sincerely yours,
John W. Ferree, M. D.
Executive Director
National Society for the
Prevention of Blindness

THE MONTH IN WASHINGTON

Politics now overshadows all other factors in the issue of health care for the aged.

It appears certain to be a major issue in this year's campaigning for the White House and Congress, regardless of what Congress does in the field before adjourning this summer.

Both the Democrats and the Republicans are supporting costly, sweeping plans which differ on the basic approach. The major Democratic plans call for

use of the Social Security System. The Republican proposals would have the Federal government and the states put up hundreds of millions of dollars to help the aged buy health insurance on a voluntary basis.

The medical profession and allied groups oppose these political solutions because, among many other important reasons, they actually would not meet the problems of many aged who need help in financing the cost of illness.

Meanwhile, a key Democrat—Rep. Burr Harrison of Virginia—warned Congress against acting on such legislation in this year of a national election. He predicted that if any such legislation should be approved this year, it “would be certain to be a monstrosity.”

Noting that various solutions had been proposed, Harrison said:

“The only features which these proposals have in common are that they are all tremendously expensive; they all propose revolutionary change, and they are all complicated, uncertainly-based and little-understood by the prospective beneficiaries.”

Harrison, who is a member of the House Ways and Means Committee which handles such legislation, urged that Congress defer action until next year. He recommended that, in the meantime, the Ways and Means Committee “conduct an exhaustive study of the various proposals.”

In early May, the Eisenhower Administration unveiled a Federal-State, \$1.2 billion-a-year plan to help the aged with limited incomes buy broad medical and hospital insurance coverage. Under the plan, an aged person—if able financially—would bear part of the cost of both the insurance and of the medical care and hospitalization.

Arthur S. Flemming, Secretary of Health, Education and Welfare, and Vice President Richard M. Nixon stressed that participation by the aged in the Administration program would be on a voluntary basis.

The Administration's plan immediately ran into widespread opposition. Dr. Louis M. Orr, Orlando, Fla., President of the American Medical Association, said it was based “on the false premise that almost all persons over 65 need health care and cannot afford it.”

“This is not a fact,” Dr. Orr said. “The truth is that a majority of our older people are capable of continuing a happy, healthy, and, in many cases, productive life. Of the more than 15 million persons in the nation over 65 years of age, only 15 per cent are on old-age assistance.”

Dr. Orr said neither the Administration's proposal nor the Forand-type Social Security approach is tailored to meet the problems of the undetermined number of older persons who, “although able to finance other costs, find it difficult to withstand the additional burden of the cost of illness.”

Dr. Orr advocated the AMA's positive eight-point program for the health care of the aged as a “sensible, economical” plan that would preserve freedom as

well as promote security. If both these objectives are to be realized, Dr. Orr said, health care programs for the aged "must necessarily be limited to support for the needy aged and leave to voluntary, competitive, private enterprise, those activities needed to improve the health care of the rest."

In brief, the AMA program comprises: 1) improved preventive medical care for the aged; 2) a state-administered program of Federal grants-in-aid to states for liberalization of existing old-age assistance programs so that the near-needy could be given health care without having to meet the present rigid requirements for indigency; 3) better nursing home facilities for the long-term care of aged persons, especially those over age 75; 4) rapid development of health insurance and prepayment policies to provide long-term nursing home care; 5) expansion of home nursing care services; 6) elimination of compulsory retirement and a basic change in the attitude that a person who reaches 65 has suddenly become non-productive and senescent; 7) health education to instill a "will to live" in older persons and to make them aware of the need for continuing healthful nutrition; and 8) anti-inflationary curbs to maintain the purchasing power of fixed pension and annuity benefits.

A Republican lawmaker, Sen. Barry Goldwater of Arizona, denounced the Administration's plan as "socialized medicine" and a "dime store new deal." The outspoken conservative predicted its ultimate cost would be "staggering." He said the Administration could have done better by proposing "full deductions for taxes for any amount spent for medical care of anyone" and for full costs of health plans by either an individual or corporation.

In endorsing the Administration's plan, Vice President Nixon charged the Forand-type proposals backed widely by Democrats would "open the door for socialized medicine," He said:

"The Forand bill and similar plans would set up a great state program which inevitably would head in the direction of herding the ill and elderly into institutions whether they desired this or not. Such a state program would threaten the high standards of American medicine."

Sen. Pat McNamara (D., Mich.), Chairman of the Senate Subcommittee on Problems of the Aged, headed a group of 16 Senate Democrats who sponsored legislation that would provide hospitalization and medical care for virtually all the nation's older persons.

The co-sponsors included three avowed candidates for the Democratic nomination for president—Sens. Hubert H. Humphrey (Minn.), John F. Kennedy (Mass.) and Stuart Symington (Mo.).

Cost of the McNamara legislation was estimated at \$1,578,000,000 a year. This would be financed by a one quarter per cent increase in the Social Security tax and 370 million dollars from general tax money.

A COMMENT FROM THE AMA ON THE AMERICAN ASSOCIATION OF DOCTOR'S NURSES

An organization called the American Association of Doctor's Nurses recently issued a news release stating that "the American Medical Association will loan a part of its large collection of exhibits" to this group's convention in Miami, Florida, June 23 to 26, 1960.

This is an incorrect statement. The American Medical Association has not loaned any exhibits to this group.

Originally known as the American Registry of Doctors' Nurses, this organization, which mailed its promotional materials from Marianna, Florida, was said to be in violation of the Nurses Practices Act in Florida in 1958 by the Attorney General in that state.

The group moved to Washington, D. C. Last summer the Federal Trade Commission charged this group with misrepresenting itself as a nonprofit organization and with giving customers the means to misrepresent themselves as registered, graduate or licensed nurses. The organization changed its name to the American Association of Doctors' Nurses and in a news release issued some months ago stated that "The American Association of Doctors' Nurses . . . has assumed the membership of the old American Registry of Doctors' Nurses."

A copy of a summary of the Federal Trade Commission complaint and a copy of the American Association of Doctors' Nurses news release regarding the name change are attached for your information.

FEDERAL TRADE COMMISSION NEWS SUMMARY

Washington 25, D. C.

Complaint (7526)—Representation July 10, 1959

American Registry of Doctor's Nurse, 1366 National Press Bldg., Washington, D. C., has been charged by the Federal Trade Commission with misrepresenting that it is a non-profit organization, and with giving customers the means to misrepresent themselves as registered, graduate or licensed nurses.

Ralph Z. Bell, Robert L. S. and Evelyn W. Bickford, and Phillip Sellers, the concern's officials, also are cited in the FTC's Complaint.

The respondents sell memberships in the organization, insurance policies, certificates, pins, emblems, and other insignia and indicia to persons employed in doctors' offices.

The complaint charges that their business is not a non-profit organization of professional nurses, as implied by the trade name, but is purely and simply a money-making operation conducted solely to sell these items.

Contrary to the trade name and claims in promotional material, the complaint continues, the business operation is not a certifying accrediting or qualifying body; and the respondents have no

authority and are wholly incompetent to establish requirements for doctors' nurses or to certify that applicants have met such requirements.

THE AGED

Dr. James A. Appel, Lancaster, Pa., a member of the AMA Board of Trustees, testified before a Senate Subcommittee that the greatest health problem faced by older people is "their isolation from the rest of society." He said:

"The health problems of the aged can only be solved within the context of total health. They involve far more than hospitals or a doctors' care. They involve the older person's other requirements in life, whether these be housing, recreation, community understanding and acceptance, the right to be useful, the courtesy of being treated as individuals, or the opportunity of living as self-reliant, respected members of society."

As for an aged person being denied medical care because of a lack of money, Dr. Appel said emphatically:

"Medical care is available to every man, woman, and child in the United States regardless of his or her ability to pay for it.

"That care is not now denied, nor will it be denied."

The Month In Washington

A new edition of *Textbook of Pediatrics* has become something of a collector's item at medical schools. The work, 1462 pages long, was edited by Dr. Waldo E. Nelson of Temple University. Dr. Nelson, however, did not compile the index. That job was done by someone who obviously didn't care much for the book, or for pediatrics.

Listed among the B's, between "Biotin" and "Birth" is this entry: "Birds, For the—Pages 1-1462."

—*Detroit Free Press*

Dr. Hilla Sheriff was elected president of the Association of State Maternal and Child Health and Crippled Children's Directors at its biennial meeting held in New Orleans April 19-22.

This is a national organization of persons directly responsible for the administration of state maternal and child health and crippled children's programs, and its major concern is policies and program planning concerning the improvement of the health of mothers and children.

Dr. Sheriff's specialty is pediatrics, and she has been Director of the Maternal and Child Health Division of the S. C. State Board of Health since 1941.

1. *Postoperative Chylothorax* by Wendell M. Levi, Jr., M. D., (Sumter) and Edward F. Parker, M. D., (Charleston). *Am. Surgeon*: 25:960-964 (December, 1959)

Chylothorax following cardiovascular and other intrathoracic operations as reported in the literature is an infrequent occurrence. To date, there have been



"By paying an additional premium you get a larger hospital room, an extra doctor and a bigger bedpan!"

22 cases reported following cardiovascular operations. Eight of these 22 cases required re-operation and were treated successfully by ligation of the thoracic duct.

Two additional cases of postoperative chylothorax are described in this report. One of these required re-operation and was treated successfully by ligation of the thoracic duct. The other recovered with non-operative treatment.

The history of chylothorax, its classification, diagnosis, and treatment are reviewed.

2. *Spontaneous rupture of renal neoplasms: review and report of a case of ruptured renal cell carcinoma* by Wendell M. Levi, Jr., M. D., (Sumter) and Bernard E. Ferrara, M. D., (Charleston) *Am. Surgeon*: 25:4 (April, 1959)

There have been nine previously reported cases of spontaneous rupture of renal neoplasms, with no known report of a case secondary to a ruptured renal cell carcinoma.

The literature is reviewed and a case is presented of spontaneous rupture of a renal cell carcinoma, which presented itself as an acute abdominal catastrophe and simulated a ruptured abdominal aortic aneurysm. Her symptoms were that of an acute abdominal catastrophe and shock, with a progressively enlarging mass in the left flank. A left thoraco-abdominal approach gave excellent exposure of the operative area and also enabled proximal and distal control of the thoracic and abdominal aorta. Retrograde pyelography failed to reveal extravasation or sufficient evidence to warrant a diagnosis of ruptured renal neoplasm preoperatively.

REPORT OF MEMORIAL COMMITTEE
SOUTH CAROLINA MEDICAL ASSOCIATION
1959-1960

As is our custom, we come together at this time to honor the memory of those friends and colleagues who have departed this life since our meeting a year ago. The following past members of the South Carolina Medical Association have died within the past twelve months.

CHARLES OSCAR BATES	Greenville	1959
L. KENT BEST	Charleston	Jan. 19, 1960
W. CHARLES BOLT	Anderson	Jan. 9, 1960
ARCHIBALD J. BUIST, JR.	Charleston	Apr. 21, 1960
JAMES WILLIAM DAVIS	Clinton	Nov. 4, 1959
EUGENE B. GAMBLE	New Zion	July 22, 1959
THOMAS B. HARPER	St. Stephen	Jan. 6, 1960
JUDSON A. MILLSPAUGH	St. George	Mar. 4, 1960
GEORGE T. PEEL	Anderson	1959
WALKER H. POWE, SR.	Greenville	May 24, 1959
LUTHER A. RISER	Columbia	Mar. __, 1960
CHANDLER M. SCOTT	Hartsville	June 14, 1959
JAMES EDWARD SCOTT	Charleston	June 29, 1959
JOHN C. SEASE	Little Mountain	Dec. 31, 1959
EUGENE A. THOMASON	Fountain Inn	Feb. 25, 1960
JAMES A. THOMASON	Fountain Inn	Sep. 25, 1959
CHARLES P. VINCENT	Laurens	Dec. 5, 1959
WALTER H. WATSON	Greenville	Aug. 15, 1959
I. RIPPON WILSON, SR.	Charleston	June 14, 1959
CLAUDE H. WORKMAN	McCormick	Nov. 15, 1959
MASON P. YOUNG	Anderson	Feb. 6, 1959

The lives these men have lived speak plainly to those who knew them well—and we can best honor them by the lives we continue to live. As expressed by Thomas á Kempis, "A life without purpose is a languid, drifting thing. — Every day we ought to renew our purpose, saying to ourselves: This day let us make a sound beginning, for what we have hitherto done is nought. — Our improvement is in proportion to our purpose. — We hardly ever manage to get completely rid even of one fault, and do not set our hearts on daily improvement. — Always place a definite purpose before thee."

Submitted by the Memorial Committee

Martin M. Teague, Chairman

Thomas G. Goldsmith

E. Kenneth Aycock

NEWS

STATE BOARD OF HEALTH

A regular meeting of the Executive Committee of the State Board of Health was held on Wednesday, March 23, 1960.

The State Health Officer, as a part of his report, requested Mr. W. T. Linton to report on some of the activities under his supervision, particularly the anthrax situation at the Arel-Dillon Manufacturing Company. Four cases have occurred there, in employees who handle goat hair, which has been imported from areas (Iran and Pakistan) where anthrax is prevalent. It is presumed that this hair has been pulled from animals which have died as a result of anthrax. Several cases have occurred in the past in North Carolina at a mohair plant, and legislation was enacted requiring sterilization of the hair before it is processed. Apparently no precautions have been taken at this plant to safeguard employees or prevent the spread of the disease, nor have employees been advised of potential dangers, safeguards to be employed, etc.

The National Anthrax Surveillance group from the U. S. Public Health Service was called in to investigate this mill. They found that all health rules were disregarded, etc., and recommended immediate correction or closing of the plant. It appears that utter disregard of all health rules and regulations has been the practice at this plant prior to the outbreak of anthrax. It was the opinion of this advisory group that if the plant is allowed to continue in operation, twenty-four hour per day surveillance would probably be necessary, which made it undesirable.

On March 22 there was a meeting of the President of Clemson College, Chairman of the Board of Trustees of Clemson, representatives from the Animal Husbandry Department, the Governor's Office, and the Cotton Manufacturers' Association, Dr. Peebles, and Mr. Linton. The consensus of this group was that sterilization of the material was essential.

Certain recommendations made by the National Anthrax Surveillance Unit from the Public Health Service have been received; however, they were received after the above-mentioned conference, so that there has not been sufficient time to work up rules and regulations. Probably the Attorney General will handle this case and no doubt prosecution will occur.

It was moved by Dr. Stokes, seconded by Dr. Smith, that the State Health Officer be instructed to proceed with the Attorney General on any legal actions necessary to correct this situation. Passed.

Minimum standards for obtaining approval for construction of public swimming pools, and regulations on the operation of artificial swimming pools were presented by Mr. Linton. It was moved by Dr. Camp, seconded by Dr. Busbee, that these rules and regulations be approved. Passed.

Mr. Linton reported that for the past nine months the U. S. Public Health Service and Charleston Water Supply officials, in cooperation with the State Board of Health, have been conducting a study to determine whether or not the raw water contained dangerous amounts of insecticide or herbicide. Thus far it appears that there is no cause for concern.

Dr. Peebles reported on research funds available to the Board of Health.

The resignation of Dr. O. A. Alexander as part-time health officer of Darlington County was announced by Dr. Peebles. A resolution was read from the Darlington County Medical Society concerning the services of Dr. Alexander.

Dr. Peebles called the attention of the Executive Committee to honors given various Board of Health personnel. Dr. Stokes moved, seconded by Dr. King, that the Executive Committee write letters of commendation to Miss Ficquett and Dr. Sheriff. Passed.

Dr. Stokes moved, seconded by Dr. Owens, that the Executive Committee go on record as opposing any change in the present law governing the practice of osteopathy in this State. Passed.

PARKER ELECTED HEAD OF STATE TB GROUP

Dr. Edward F. Parker, of Charleston, was elected president of the South Carolina Tuberculosis Association at the Association's annual meeting in Columbia.

Dr. Parker is a graduate of the University of South Carolina and the Medical School of Duke University and has worked in hospitals in New York, Tennessee, Virginia, Georgia and South Carolina. With the U. S. Army Medical Corps from 1942 to 1946, he served almost two and a half years in North Africa and Italy. He was awarded the Bronze Star in 1945 as chief of the Thoracic Surgery Service and was discharged in 1946 with the rank of Lieutenant Colonel. He was appointed clinical professor of surgery at the Medical College of South Carolina in Charleston in 1958.

Doctor Parker has served on the board of directors of the Charleston County Tuberculosis Association, the board of directors of the S. C. Tuberculosis Association, and representative councillor on the Board of the American Trudeau Society.

Other officers of the state Association are: James B. Caughman, Columbia, first vice president; Dr. S. E. Miller, Georgetown, second vice president, and Thomas F. Maurice, Aiken, secretary.

The S. C. Trudeau Society medical section of the State Association, also elected new officers: Dr. James W. Fouché, Columbia, president; Dr. Martin M. Teague, Laurens, vice president, and Dr. Edmund R. Taylor, Columbia, secretary-treasurer.

Among Directors-at-Large re-elected are: Dr. Robert Black, Baniberg; Dr. J. C. Parker, Orangeburg; and Dr. J. Gordon Seastrimk, Columbia.

GRANTS MADE

Two in-service training grants totaling \$700.00 have been made to South Carolina mental health personnel by the Southern Regional Education Board under its program in mental health training and research. To date, 12 SREB grants have been awarded to South Carolina mental health employees under this program.

Grants were made to Dr. Joe E. Freed, chief of the women's department, and Dr. Edward M. Burn, assistant physician in the women's department, of South Carolina State Hospital, Columbia. They will visit eight hospitals in New York and Pennsylvania to study programs of treatment of aged patients.

The SREB in-service training grants were made possible by a \$90,000 grant for this purpose by the National Institute of Mental Health.

DR. FLEMING IS NAMED TO CANCER POST

Dr. John Fleming of Spartanburg was elected medical delegate member of the American Cancer Society for the South Carolina Division at a meeting of the Board of Directors of the Division recently, it was announced yesterday by Brig. Gen. William N. Cork, Ret., president. General Cork was elected lay delegate member at the same time.

Dr. Fleming replaces Dr. Harold Pettit of Charleston, whose term of office expired this year, General Cork said. He replaces Audley H. Ward, Aiken, who has just completed two years' service in this post. Both memberships are for a two-year term.

Gen. Cork announced that the Division will send one of the speakers to the S. C. Medical Association meeting at Myrtle Beach May 18 and 19. He is Dr. A. R. Curreri, whose subject will be "Hormones and Chemotherapy of Cancer." Other participants on the medical panel include Dr. Forde McIver, who will serve as moderator; Dr. Edward Krementz and Dr. Charlton DeSaussure.

Plans were made for Dr. Fleming and Gen. Cork to attend the regional meeting in Miami, Fla., on May 21 and 22. They will be joined by Dr. James R. Young, Anderson, a member of the National Board of Directors; Mrs. Paul H. Leonard, Executive Director of the Division, and other state delegates. Dr. Fleming and Gen. Cork will be formally elected to their new posts at the Miami meeting.

DR. HARRISON OPENS OFFICE

Dr. A. Frank Harrison, III, formerly associated with Dr. Thomas W. Talbert, announced the opening of his office at 1506 Gregg St., Columbia, S. C., for the practice of general medicine.

Dr. Harrison attended the Columbia city schools. He served in the United States Navy from 1948-52.

Dr. Harrison was graduated from the University of South Carolina in August, 1955. He was graduated from the Medical College of South Carolina in December, 1958, and served his internship at the Columbia Hospital.

DR. C. RAM WINS HONOR

Word was received from Dr. James L. Campbell of Orlando, Florida that Aiken Urologist Dr. Cecil C. Ram, has been elected an associate member of the Southeastern section of the American Urologist Association.

Dr. Ram opened his offices in the Ram Building in Aiken last July, and is a practicing urologist.

Joseph L. Kurtzman, M. D. announces that he has assumed the ophthalmology practice of the late Dr. L. Kent Best, 107-G Ashley Ave., Charleston.

The Coastal Medical Society held a meeting on April 21st at Edisto Grill, Jacksonboro. The speaker was Dr. John Van De Erve, who presented a paper on "Griseo and Moniliasis".

ALEXANDER RETIRES AS HEALTH OFFICER

Dr. O. A. Alexander, Darlington County health officer for 10 years, has resigned. He will continue his private practice.

The County Board of Health has adopted a resolution of regret at Dr. Alexander's resignation. The board commends him for "his efficient and excellent service" and regrets "that he has found it necessary to resign." The board wishes him "many more years of successful private medical practice."

PSYCHIATRIC GROUP NAMES DR. BECKMAN

Dr. W. P. Beckman of Columbia, State director of mental health, was named president-elect of the South Carolina District Branch, American Psychiatric Association, at the annual meeting at the Jefferson Hotel in Columbia March 31.

Other officers for 1960-1961 are: President, Dr. Iverson O. Brownell of Greenville, psychiatrist and director of the mental health clinic there; secretary-treasurer, Dr. Joseph J. Nannarello of Greenville, private practicing psychiatrist. Two counselors, Dr. James R. Galloway of Columbia, private practicing psychiatrist; and Dr. R. Ramsey Mellette, Jr., Department of Psychiatry, Medical College of South Carolina, Charleston.

Dr. William S. Hall, superintendent, S. C. State Hospital, and the first president, South Carolina District Branch, APA, was elected as the delegate to the American Psychiatric Association Convention in Atlantic City, New Jersey, in May 1960; with Dr. William G. Morehouse, S. C. State Hospital, as the alternate.

This first independent meeting to be held by the South Carolina District Branch was interesting and stimulating with a panel discussion of, "The Diverse Problems Encountered in the Private Practice of Psychiatry." The moderator was Dr. Edward M. Burn, South Carolina State Hospital; and the panelists, Dr. James B. Galloway; Dr. Joseph J. Nannarello; and Dr. Jennings J. Cleckley, Department of Neuropsychiatry,

Medical College of South Carolina, Charleston.

Dr. Joe E. Freed, chief, women's department, Columbia Division, S. C. State Hospital, as 1959-1960 president, South Carolina District Branch, APA, presided during this meeting.

OFFICERS ARE NAMED BY HEART ASSOCIATION

Dr. R. Cathcart Smith of Conway has been re-elected as president of the South Carolina Heart Association.

He was named during a meeting of the general membership held along with the association's 11th annual scientific session.

Other officers named were Albert R. Simonds of Charleston, vice-president; Dr. Allan B. Warren of Spartanburg, secretary; O. W. Farrell of Columbia, treasurer; Dr. John A. Boone of Charleston, board chairman, Robert C. Burton of Columbia was re-elected executive director.

Elected to the board of directors were Dr. James L. Wells of Orangeburg; Dr. Charles H. White of Sumter; Dr. Peter C. Gazes of Charleston; Dr. J. P. Coan of Spartanburg; Dr. John C. Muller of Greenville; William H. Culverius of Charleston; Thomas H. Pope of Newberry; W. Hugh McGee of Anderson; and John G. Martin of Columbia. Robert N. Jones of Greenwood and Mrs. Ray Kirby of Gaffney were named to fill unexpired terms on the board of directors.

Charlestonians Honored

Two Charlestonians and a former resident were honored during the annual meeting.

Dr. Boone, chairman of the Dept. of Medicine, Medical College of South Carolina, was awarded the Distinguished Service Award.

This is the "highest honor the association can bestow and which goes to those having shared effectually in the activities of the association for a period of three years or more and have rendered distinctive leadership and service," officials said.

Mrs. Peter C. Gazes of Charleston received the Meritorious Service Award, which annually goes to volunteers throughout the state who have performed the "resplendent service in the Heart Fund Campaign and year-round programming."

Dr. Frederick E. Nigels, Jr., a former Charlestonian now residing at Myrtle Beach, was among those receiving the Meritorious Service Award. Dr. Nigels is a graduate of the College of Charleston and the Medical College.

Others receiving the Distinguished Service Award were Dr. William Schulze of Greenville, Dr. A. Izard Josey of Columbia, and Dr. George R. Wilkinson of Greenville.

DR. W. H. LEE PRESENTS TOP RESEARCH PAPER

Dr. William H. Lee won first place for a paper presented at the Southeastern Surgical Congress in New Orleans, La.

The congress each year selects a first place winner from residents in surgery throughout the southeastern area. Dr. Lee is both a resident in surgery and an advanced clinical trainee of the National Heart Institute at the Medical College of South Carolina.

Dr. Lee's winning paper was entitled "The Effects of Commonly Used Vasodilators on the Blood Pressure and Contractile Force of the Heart". In it, he told of work going on at the Medical College to determine the effectiveness of vasodilator drugs.

Dr. Lee is a graduate of the High School of Charleston and the College of Charleston, as well as the Medical College of South Carolina.

Two other Charleston doctors presented papers at the convention. They were Dr. J. Manly Stallworth and Dr. Gilbert B. Bradham, both assistant professors of surgery at the Medical College. The speakers were chosen on the basis of abstracts of their papers submitted to the convention.

DR. PARKER IS NAMED BY ROPER BOARD

Dr. Edward F. Parker has been elected chairman of Roper Hospital's board of commissioners.

He succeeds the late Dr. Archibald Buist, Jr.

Also elected at the meeting of the commissioners was the vice chairman, Dr. Joseph I. Waring.

Dr. Clyde F. Bowie has been elected to the Anderson County Health Board by the county's medical society. He was named to replace Dr. Mason Young, who died last month. The medical society elects three members to the health board with members usually succeeding themselves each year.

Dr. John T. Roper, York physician, gave up his practice in York late in May and on July 1 will begin a four year residency in Orthopedics at Memorial Hospital in Charlotte, N. C.

Dr. Roper came to York in April 1957 and took over the practice of his late uncle, Dr. Charles P. Roper.

Dr. Roper was graduated from Wofford College and the Medical College at Charleston. He interned in Madigan Army Hospital in Tacoma, Washington, and did his surgical and eye, ear, nose and throat at Brooks Army Hospital, San Antonio, during his service in the armed forces. He was a captain in the U. S. Army serving from July 1956 to March 1957.

He came to York after his discharge from the Army. His going will leave York with only three doctors, Drs. Strong, Pratt and Hiott.

The Rt. Rev. C. Alfred Cole, bishop of the upper diocese of South Carolina of the Protestant Episcopal Church, announced a church-sponsored medical center at Ridgeway May 1.

Ridgeway has had no resident physician for a number of years.

The vestry of St. Stephen's church at Ridgeway undertook the project, enlisting support from the

upper diocese and the national council of the church.

Funds were raised to purchase and renovate a building for an office and clinic. Dr. Frank L. Culbertson of Laurens, a World War II Navy pilot and graduate of the S. C. Medical College, will have charge.

Announcement was made that Dr. Carl H. Strom will arrive in McCormick soon to begin the practice of medicine. He will occupy the offices of the late Dr. C. H. Workman.

Dr. Strom, a native of McCormick, is the son of Dr. and Mrs. C. R. Strom.

After graduating from McCormick High School, Dr. Strom received a degree from the University of Georgia, attended premedical school at Guilford College, N. C., and graduated from the Medical School in Charleston. He served his internship at Spartanburg General Hospital, Spartanburg, and at present is engaged in the practice of medicine at Cliffside, North Carolina.

COLUMBIA MEDICAL SOCIETY

The members of the Columbia Medical Society were guests of the Medical Staff at the U. S. Army Hospital, Fort Jackson, S. C., for their May scientific meeting. The meeting was held at the Legion Lake Officers' Club, Fort Jackson, May 9, 1960.

Following the call to order by Dr. W. A. Hart, President of the Columbia Medical Society, the meeting was presided over by Col. Roland K. Charles, Jr., Commanding Officer of the Fort Jackson Army Hospital. Speakers for the meeting were Col. John C. Patterson and Captain Charles G. Mendelson, Fort Jackson Army Hospital. Col. Patterson spoke to members of the Society on the subject "Surgery in Histoplasmosis—Experience in the Management of One Hundred and Three Proven Cases Involving the Lung and Mediastinum", and Captain Mendelson discussed "Isolation of Wart Virus in Tissue Culture and Subsequent Re-inoculation into Human Volunteers".

For some years the Columbia Medical Society has been privileged to have the various institutional hospitals in the city act as hosts for its summer meetings. The Veterans Hospital of Columbia will be the host for the June Scientific Meeting, the South Carolina Sanatorium for the July meeting, and the August meeting will be held at the South Carolina State Hospital.

The meetings at the hospitals are always enjoyed by Columbia physicians and afford an excellent opportunity to bring them up-to-date on the various activities in which the hospitals are engaged, and the progress which each hospital is making. In addition, all members of the "medical community" of Columbia are drawn closer together through the fellowship enjoyed at these meetings.

DR. WARING REPORTS ON HOLT PAPERS

Dr. J. I. Waring reported on the papers of Dr.

William Joseph Holt at the 24th annual meeting of the South Caroliniana Society on April 28th, at Columbia.

Dr. Holt, a graduate of the South Carolina College in 1849 served as surgeon with the Russian forces during the Crimean War.

COLLEGE OF CHARLESTON AWARDS HONORARY DEGREES

The College of Charleston awarded two honorary Doctor of Laws degrees at its 175th commencement exercises May 31 to members of the South Carolina Medical Association.

The two men honored are Dr. Leon Banov, Charleston County Director of Health and professor of preventive medicine at the Medical College of S. C., and Dr. Joseph Dechard Guess of Greenville.

Dr. Banov attended the Medical College where he obtained a graduate degree in pharmacy in 1907 and the M. D. in 1917. He has taught at the College since 1913 in the fields of preventive medicine and public health. He was appointed Asst. Charleston City Bacteriologist, 1912-18; Chief Food Inspector, 1918-20; County Health Officer, 1920-26; City and County Health Officer, 1926-36 and to his present position, Charleston County Director of Health in 1936.

He has served as an American delegate to the International Hygiene Congress in Dresden, Germany; a member of President Harry S. Truman's National Health Assembly and a member of the first national conference on cardiovascular diseases. Dr. Banov is a fellow of the American Public Health Assn. and of the American College of Preventive Medicine. He is also a member of several medical and public health associations of both sectional and national importance.

Dr. Banov's services to the community include the initiating of dairy inspections which resulted in the passing of an ordinance in 1918 requiring the pasteurization of milk, thereby making Charleston the first American city to require the pasteurization of its entire milk supply. Under his direction the city and county eliminated smallpox in 1929 and practically eliminated typhoid and malaria. A new health center now being constructed is to be named in his honor.

Dr. J. Dechard Guess graduated from the College of Charleston in 1911 and from the Medical College in 1917. He later attended the University of Pennsylvania for graduate courses in medicine.

He was elected president of the S. C. Medical Association in 1951. He served as secretary of the Greenville County Medical Society and later as president. He has been a trustee of the Medical College since 1945.

Dr. Guess was founder and an early president of the Piedmont Post Graduate Assembly. He helped organize the S. C. Obstetrical and Gynecological Society and the South Atlantic Association of Gynecologists and Obstetricians. He is a founding fellow of the American College of Obstetrics and Gynecologists. He is also president of the Greenville Rotary Club.

ANNOUNCEMENTS

The Annual Obstetrical-Pediatric Seminar sponsored by the Maternal and Child Health Divisions of Florida, Georgia, Alabama and South Carolina will be held at Ellinor Village, Daytona Beach, Florida, August 18-20, 1960.

The program is as yet incomplete. Detailed information about the meeting may be obtained from Dr. Hilla Sheriff, State Board of Health, Columbia, S. C.

FELLOWSHIPS AVAILABLE

Fellowships for qualified students are available for a graduate teaching program in Maternal and Child Health established by The University of Michigan, School of Public Health. The program is open to physicians, nurses, nutritionists and social workers who meet the admission requirements. Each of the fellowships is designed to cover tuition, academic fees, and reasonable living allowance during residence at the University. Assistance is also available to properly qualified candidates from other sources.

For further information write:

Secretary of the Faculty
School of Public Health
The University of Michigan
Ann Arbor, Michigan.

A. M. A. INDUSTRIAL HEALTH CONGRESS TO BE HELD IN NORTH CAROLINA

Representatives of industry, agriculture, medicine, and governmental agencies will gather in Charlotte, N. C., Oct. 10-12, for the 20th Congress on Industrial Health.

To be held at the Hotel Charlotte, the congress is sponsored by the American Medical Association's Council on Occupational Health and is held each year as a means of furthering the development and maintenance of high medical standards in industry and on the farm.

The congress programs are primarily directed toward the general practitioner, whom, it is estimated, handles close to 90 per cent of all the occupational medical practice in the nation.

The Civil Service Commission announced in April approval of the 13 Federal employee organization health benefit plans and the 22 comprehensive medical plans to be offered under the Federal employees health benefits program when it goes into effect in July, 1960. Contracts will be signed as soon as final details are worked out, the Commission said.

The Commission has recently approved the Government-wide indemnity benefit plan offered by Aetna Life Insurance Company of Hartford, Connecticut, and the Government-wide service benefit plan offered by Blue Cross-Blue Shield.

Approximately 1,800,000 Federal employees are expected to enroll in the new health benefits program for themselves and their more than 2,200,000 dependents under one or another of the plans offered. The enrollment period will be June 1 through June 30.

The high enrollment expected and the wide variety of choice of plans and options offered make this program the largest and most complex employer-sponsored voluntary program of health benefits in the world, the Commission said. The Government will contribute up to half the cost of each health benefits plan, with the employee paying the balance of the cost of the plan he chooses through payroll deductions. The volume of first-year premiums is expected to approximate \$250,000,000.

All of the Federal employee organization plans approved are of the indemnity benefit type. These plans will reimburse the enrolled employee for costs of covered health care services. The plans will offer a high and low option of benefits, each with premiums related to the value of the benefits offered. Most of the employee organization plans will also offer basic and major medical coverage in both options. To join one of these plans the employee must be a member of the organization at the time he selects the plan.

The comprehensive medical plans are of the group- or individual-practice prepayment type. They offer a broad range of medical services and hospital care. Slightly fewer than half of the comprehensive plans will offer two levels of benefits. Each of the comprehensive medical plans provides health care services in a specific geographic area.

The Scientific Exhibit AMA Clinical Meeting, Washington, D. C. November 28 - December 1, 1960

Application forms for space in the Scientific Exhibit at the Washington, D. C. Clinical Meeting of the American Medical Association, November 28 to December 1 are now available. They may be procured by writing directly to Charles H. Bramlitt, M. D., Director, Department of Scientific Assembly, American Medical Association, 535 N. Dearborn St., Chicago 10, Illinois. Applications close on August 1.

The "Hull" award will be presented for the first time at this meeting to the best exhibit on a scientific subject which has not been previously shown at a medical meeting. The award will consist of a gold medal and an honorarium of \$250. The winning exhibit will be approved for showing in the Scientific Exhibit at the 1961 Annual Meeting of the AMA which will be held in New York City.

Dr. Thomas G. Hull will personally present the award to the recipient.

THIRD INTERNATIONAL CONGRESS OF PHYSICAL MEDICINE

The Third International Congress of Physical Medicine will be held August 21-26, 1960 inclusive, at the Mayflower, Washington, D. C.

The preliminary prospectus covering the international conference carries in detail information on registration, application to present a paper, a scientific exhibit, a scientific film, etc. A copy of this preliminary program may be had on request by writing: Dorothea C. Augustin, Executive Secretary, Third International Congress of Physical Medicine, 30 N. Michigan Avenue, Chicago 2, Illinois.

Institutes in the Care of Premature Infants
at
The New York Hospital — Cornell Medical Center
New York City

The Institutes for Physicians and Nurses in the Care of Premature Infants are being continued at the New York Hospital—Cornell Medical Center under the sponsorship of the New York State Department of Health and the U. S. Children's Bureau. These Institutes are designed to meet the needs of physicians and nurses in charge of hospital premature nurseries and special premature centers and of medical and nursing directors and consultants in state and local premature programs.

Institutes for the 1960-61 fiscal year are definitely scheduled to start on the following dates:

September 19, 1960

November 28, 1960

January 23, 1961

March 13, 1961

May 8, 1961

EARLY APPLICATION for these Institutes is ESSENTIAL.

Method of Application

Applications by physicians should be forwarded (after approval by the health commissioner or the director of Maternal and Child Health of the state in which the candidate works) to:

Dr. Charles H. Bauer, Medical Director
Institute in the Care of Premature Infants
Department of Pediatrics
The New York Hospital
525 East 68th Street
New York 21, New York

**CLINICAL STUDY OF CHILDHOOD
SOLID TUMORS**

The cooperation of physicians is requested in a therapeutic study of childhood solid tumors at the Clinical Center, National Institutes of Health, Bethesda, Md. This study is being conducted by the National Cancer Institute and has as its primary purpose a search for therapeutic agents that favorably affect the course of the disease.

Physicians interested in the possibility of referring patients should write or telephone:

Dr. Clyde O. Brindley
Senior Investigator
National Cancer Institute
Bethesda 14, Maryland
(OLiver 6-4000, Ext. 4252)

MEDICAL ASSISTANT FILM AVAILABLE

"First Contact", a 26-minute color film about the American Association of Medical Assistants will soon be available to medical societies and AAMA groups for use in promoting membership or helping organize local groups. The film, produced for AAMA by Wyeth Laboratories in cooperation with the AMA, illustrates how a good assistant is good public relations for M. D.'s and how AAMA helps her develop her skills on the job.

If your society has been called on to help program a medical assistants meeting, you can borrow the film after from AMA's Department of Medical Motion Pictures and Television. AAMA chapters can obtain prints from their national headquarters, 510 N. Dearborn, Chicago 10. Prints are also available on loan from the Wyeth Film Library, Box 8200, Philadelphia 1.

FORCED RESEARCH

Since this reward and those linked with research grants (travel, secretarial help, and freedom from teaching) combine lucre with glory, it is not surprising that inside the university and on its industrial and other fringes the practice or pretense of research should have become a compulsion. Thousands of young men are at work on little papers; thousands more are wracking their brains to think of an experiment or study. Most of them worry more about the acceptability of the subject in academic eyes than about their chances of doing and saying something useful, that is, few care about the fitness of the matter and none about the readability of the results. "Communication" occurs by good luck, while everybody groans ritually at the bad writing, excessive length, and prevailing insignificance of what the journals print. In a word, this army of researchers by conviction or impressment are technically pedants.

—J. Barzun, *The House of Intellect*, New York, Harper, 1959.

DEATHS

DR. A. J. BUIST, JR.

Dr. Archibald J. Buist, Jr., former chairman of the Board of Commissioners of Roper Hospital for 12 years, died April 22 at a local hospital. He resided at 48 Legare St.

Dr. Buist was born in Charleston July 25, 1905, a son of Archibald Johnston Buist, M. D. and Mrs. Alice Stock Mitchell Buist. He attended schools in Charleston and was graduated from Mercersburg Academy, Mercersburg, N. J., in 1922.

He received his A. B. degree from Princeton University in 1926 and his M. D. degree from the Medical College of South Carolina in 1930. He interned at Roper Hospital and was awarded a one year fellowship in surgery at Cleveland Clinic in Cleveland, Ohio.

He entered the practice of surgery and gynecology with his father in the early 1930s.

He entered the U. S. Navy in February, 1941, and served on sea duty and at the U. S. Naval Hospital here. He was released to inactive duty with the rank of commander in March, 1944.

He returned to the practice of surgery and gynecology in 1944 in Charleston. He was elected to the Board of Commissioners of Roper Hospital in 1944 and served as chairman since 1948, resigning this month.

He was an associate professor of surgery at the Medical College, a member of the American Medical Association, the Medical Society of South Carolina, the Charleston County Medical Society, the South Carolina Medical Association, the Southern Medical Association, the Southeastern Surgical Congress, the American College of Surgeons, the Elks, the Masons, the Charleston Club, the Carolina Yacht Club and the Charleston Yacht Club.

He was also a member of the Society for the Relief of the Families of Deceased and Disabled Indigent Members of the Medical Profession of the State of South Carolina and was treasurer of this society from 1943 to 1960.

DR. H. B. WEBB

Dr. Harold B. Webb, 56, medical supervisor of the May plant, former hospital administrator and World War II flight surgeon, died at the Kershaw County Memorial Hospital at the age of 56. He was ill several months.

Doctor Webb was born in Florida. He attended Bailey Military Academy was graduated from Columbia High School and took premed at Clemson College, where he played football on the varsity team.

Doctor Webb was graduated from the Medical College of South Carolina, interned at Roper Hospital in Charleston and took post graduate work at Lying in Hospital at St. Louis, Mo.

He practiced at Waynesboro, Va., and was instrumental in the building of the Waynesboro Hospital. He served as the hospital's first administrator. He was a major in the air force as flight surgeon in the China Burma Campaign. He was immediate past president of Kershaw County Medical Society. He had been employed by the E. I. DuPont de Nemours and company for 14 years, having been medical supervisor of the May plant for the past 10 years.

BENEFITS BY POLITICS?

Perhaps not to the identical point but nevertheless pertinent is the stand taken and openly declared by Donald L. Rogers, business and financial editor of the *New York Herald-Tribune*, in a recently published analysis. Mr. Rogers serves notice to any office seekers that he positively will cast his vote "for whichever candidates do not promise me a single, solitary 'benefit'; conversely I will vote against and militate against any who promise to improve my lot. . . . Neither I nor my children can afford any further

assistance from the people who are elected to govern us."

After calling attention to the dismal record of "our friends, the lawmakers," who have increased the federal debt to \$290,000,000,000, Mr. Rogers presents the figures of the Federal Social Security System, whose liabilities at the moment total \$361,000,000,000, of which \$340,000,000,000 must be raised by future taxes. Although the tax rate for Social Security now represents 6 per cent of taxable payrolls, almost five times more taxes will have to be collected to meet present commitments than have already been paid in.

"If only porkbarrelers like Forand and others of his stripe would let this one election pass," Mr. Rogers concludes, "without burdening us with further such 'benefits' we might be able to make it as a solvent nation in spite of our lovable lawmakers."

From: "America the Dutiful", Editorial, *New England Journal of Medicine*, Vol. 262, 16: 830.

MIND YOUR OWN BUSINESS

A few weeks ago, while attending a county medical society indoctrination luncheon, I was taken by surprise when asked to speak to those present. In the short time available to me during my introduction by the toastmaster I wracked my brain to think of something to say. The only thing that came to my mind was to say "mind your own business." I have thought about this frequently since the luncheon and still believe this was about the best advice that could be given to young men and women embarking on their careers as doctors.

It is probable that the medical profession has never faced such violent attacks from so many sources as it faces today. Nor have attempts at encroachment on the rights of physicians been so determined and so persistent as those encountered at the present time. In the form of the Forand Bill and similar proposed legislation, the specter of socialized medicine again rears its ugly head. Labor union-dominated health and welfare funds are attempting, and in some cases succeeding, to restrict the rights of doctors to serve their members and dependents. Poor public relations on the part of doctors and avarice and the chance for a "fast buck" on the part of many patients have brought about a rash of malpractice suits across the nation.

All attacks against the medical profession, of whatever kind or from whatever source, must be resisted by every legal and ethical means at our command. Effective lobbies must be developed on both state and national levels so that legislators may be fully informed as to organized medicine's attitude toward any proposed legislation which involves the health of our people and so that they may receive first-hand information as to why doctors oppose socialized medicine. The profession's public relations status must be improved. Procedures must be developed to curb the undesirable, unethical, or illegal activities of the few doctors responsible for many of our present difficulties. All of these activities will cost money. All will require sacrifices in time and effort on the

part of doctors. We must be willing to pay the price and to make the sacrifices.

At the last annual session of the State Medical Society in October, the House of Delegates authorized the inauguration of a large-scale public relations and medical economics program throughout the entire commonwealth. This will cost considerable money. Although not a single delegate voted against the program, already some grumbling has been heard even from some delegates who were present when the vote was taken. These doctors say the program is unnecessary and that good public relations can't be bought with money but must be won by the actions of individual doctors. This writer disagrees with the statement that the program is unnecessary, but is in complete accord with the claim that good public relations can't be purchased but must be deserved.

It is to be sincerely hoped that no doctor will be so naive as to think this program will solve all the problems confronting us or that any public relations and medical economics firm can itself do the job we want done. Good public relations depend upon "who is minding the store," upon the individual doctor, upon *you*. The responsibility for good or bad public relations can't be delegated to others, especially to persons outside the medical profession. These professional consultants can only do certain things. They can point out our deficiencies, our faults, and our mistakes. We will probably resent this activity by our consultants even though we recognize and admit the validity of their statements. They can also give competent, sound advice on how to correct our faults and regain high public esteem.

The Pennsylvania Medical Society has employed the best consultants available in the fields of public relations and medical economics, but this fact alone does not insure the success of the program. The effectiveness of the undertaking will be relatively little affected by the proficiency, experience, and actions of our consultants. In large part, the success of the venture and the length of time it will need to be continued will depend upon how seriously their advice is taken and how completely it is followed by individual doctors.

If you want to get a thing done the way you want it done, do it yourself. Medicine is your business. Mind your own business.

W. Benson Harer, M. D.

Contributing Editor

From: "Mind Your Own Business", Editorial, The Pennsylvania Medical Journal, Vol. 63 2:273, February 1960.

BOOK REVIEWS

PERSONALITY CHANGE AND DEVELOPMENT AS MEASURED BY THE PROJECTIVE TECHNIQUES. Molly Harrower, Ph. D. Grune and Stratton. New York, 1958, 383 pp. Price \$10.00.

The author, of Temple University Medical School,

Philadelphia, also practices clinical psychology in New York City. She presents in this book about 50 follow-up retestings of patients who have undergone different kinds of psychotherapy for varying lengths of time or who have undergone stress reductions or environmental change. She finds that changes in the psychotherapists' ratings of patients are in the same direction as the changes indicated by projective testing techniques.

She correctly stresses the importance of follow-up studies with the same individuals as being more revealing than cross sectional studies which reveal norms based on statistical averages. One highly interesting finding is that "prognosis is not necessarily more favorable in cases in which pathology is less severe. Yet in general . . . the 'better' the initial test picture, the greater the subsequent improvement will be regardless of the type of therapy employed." She reports another study which indicates "little difference in the overall effectiveness of individual therapy, group therapy, or a combination . . . (while) a control group despite a number of important life changes showed no statistically significant difference between pre- and post-tests."

Changes were measured on such variables as productivity, relation to reality, usual-unusual thought content, constructive fantasy, drive, emotional tone, social attitude, anxiety, and over-all evaluation. Tests used included the Rorschach, Figure Drawing, Drawing the Family, Thematic Apperception Test, Sentence Completion, subtests from the Wechsler-Bellevue, and —apologies from the reviewer—the Szondi.

Significant findings indicate that in successful therapy cases the therapists' behavior evaluations show greater change than do the tests. It takes considerable time for personality to be reorganized sufficiently to bring about test changes which reflect clinically observed therapeutic changes. The tests cover a wider range of aspects of the individual make-up and do not concentrate on the pathologies to so great an extent as do therapist evaluations. Retests ten years after successful psychotherapy revealed greatest improvements since the personality changes have had time to influence a wider range of performances. Changes were practically nil for all unsuccessful cases except those rated by the psychotherapist as "worse", in which cases test results reflect this deterioration. Also "when improvement in general adjustment and freedom from symptoms are reported clinically, some measure of positive change is invariably shown on the projective tests." Long term psychotherapy, whether psychoanalysis or otherwise, revealed about a 40% increase in performance and test effectiveness when the clinical changes were positive. This same degree of improvement was noted for patients whose environment underwent positive change.

This book presents the actual drawings, test scores, etc. on dozens of patients so that the reader can evaluate for himself the significance of his own hunches as well as the author's hypotheses. But this book only reports improvements as reflected by tests,

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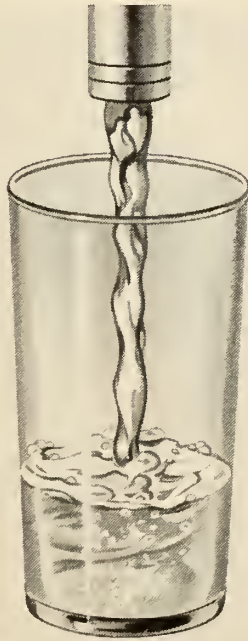
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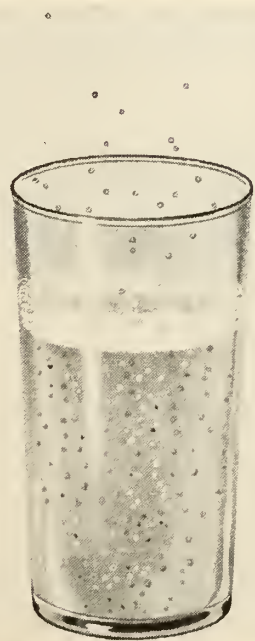
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it does not describe other methods of measuring personality growth as reflected in greater social skills, improved role-taking, better communicative powers, or a wide range of other evidences of improved effectiveness and increased satisfyingness in living.

Elmore A. Martin, Ph.D.

CURRENT MEDICAL REFERENCES, Edited by Paul J. Sanazaro, University of California. Lange Medical Publications: Los Altos, California, 1959. Price \$3.50.

This is a handbook which provides lists of good references to the literature on various clinical aspects of medical diseases. Realizing the elements of uncertainty in the selection of the references, the editor offers lists which are reasonably available to the average physician through hospital or other institutional libraries. For the student or physician who wants short but comprehensive lists of articles from the journals, it should offer a handy approach to a subject which might need amplification from further search.

The book is to be revised every two years, and should be therefore pretty close to being up to date, that is to say, as much as any book could be.

Probably one of the chief services from such a book would be to supply a teacher with a handy list to pass on to his students.

J. I. W.

FAMILY MEDICAL ENCYCLOPEDIA by Justus J. Schifferes, Ph. D. (A Health Education Council Book) PermaBooks; New York, 1959. Price: 50¢.

This is a handy and inexpensive edition of a work that has already been published in a more permanent binding. It is produced under an advisory editorial board which included a number of well-known physicians who are well qualified to pass on the accuracy of the definitions included in this book. There are not only clear and fairly long definitions of such words as are frequently used in medical matters, but there are also short essays on subjects such as deafness, endocrine glands, etc. The Encyclopedia can be heartily recommended for family use, and indeed might not be inappropriate in connection with academic studies in pre-medical matters.

J. I. W.

WHAT NEXT, DR. PECK?, by Joseph H. Peck, M. D. Prentice-Hall, Inc.: Englewood Cliffs, N. J., 1959. Price \$3.50.

This is an informal and amusing story of a young doctor who sets out to work in the primitive conditions of western Utah in 1916 and afterward. Dr. Peck describes much of his medical activity, but the chief part of the picture is life in an unglamorous western setting, from which he manages to extract much of amusement and wisdom. This reviewer derived a good deal of enjoyment from reading the book.

J. I. W.

GUIDE TO BETTER HEALTH, Harry J. Johnson, M. D., The Life Extension Foundation. Prentice-Hall, Inc.: Englewood Cliffs, N. J. 1959. Price \$4.95.

This is an excellent book for lay consumption written by a physician of very extensive experience, and covering in a very readable manner the matters which lead to improving or maintaining health. It covers such matters as sleep, fatigue, tension, diet, vitamins, etc., and takes up in adequate detail the innumerable misconceptions about such things which are dear to the public.

This book can be recommended without hesitation for general reading, and if taken seriously, should accomplish a great deal toward clarifying the unnecessarily complex conception of health and disease which seems to permeate the public mind.

J. I. W.

THE FLUIDS OF PARENTERAL BODY CAVITIES. Paul D. Hoepfich, M. D. and John R. Ward, M. D. Grune and Stratton, New York, 1959. Price: \$4.95.

The authors of this monograph have attempted to bring together the wealth of information about the fluids of parenteral body cavities that is somewhat scattered throughout the medical literature. They wish to achieve a useful compilation of information about the fluids of parenteral body cavities in a form which is at the same time a treatise extensive enough to be provocative of interest.

They furnish a useful laboratory manual detailing the techniques of aspirations of pleural, pericardial, peritoneal, joint and spinal fluids. But they go beyond this in discussing the anatomy of serous membranes and the physiology of fluid formation in them. Of interest is the discussion of the physiology of the formation of fluids and the factors rendering each unique in chemical structure.

The authors have accomplished their purpose of producing a work meriting the attention of students of medicine of all ages and specialties. This book will, however, be of particular value to the intern and house officer making his first acquaintance the clinical importance of parenteral fluids.

Arthur V. Williams, M. D.

THE RELUCTANT SURGEON: A BIOGRAPHY OF JOHN HUNTER by John Kobler. Doubleday & Co., Garden City. 1960—Price \$4.95.

This reviewer can put his stamp of approval on the many enthusiastic reviews of this book which have appeared in the major papers of the country. It presents the turbulent life of John Hunter and describes his innumerable original observations and activities. With a background of the riotous life of eighteenth century England, it offers a field of wide interest. It is a book well written, and it ranges in a most absorbing way over the total life of Hunter and of his times.

It may be recommended for delightful, interesting and instructive reading.

JIW

THE EMERGENCY SYNDROME IN PEDIATRIC PRACTICE, Alfred J. Vignec. Landsberger Medical Books, Inc.: New York 1959. Price \$9.00.

This book might find a useful place in the library of the practitioner or in the reference shelf in emergency rooms. It represents the personal experience and opinions of the author. While it is handier than the standard pediatric text-reference books, it seems to add little to what might be found in them. It would be improved by more careful attention to the details of editing.

J. I. W.

In the introduction to a paper entitled "The Doctor, His Patient and the Illness," Michael Balint of London pointed out that by far the most frequently used drug in general practice is the doctor himself, and that it is a drug without pharmacology, without directions as to dosage, form and frequency of administration, and without leads to the hazards, allergic responses or undesirable side effects. We know, however, that it is an extremely potent drug and that those who use it relieve more suffering than has yet been recorded for the most powerful drug in the pharmacopoeia. The family doctor of old knew this to be so and prescribed himself in generous doses. It is time that we recaptured this part of his art and when we do, with our new knowledge, we will be true physicians, dedicated to the practice of a God-given healing art.

—F. J. Braceland, *Pharos* of A. O. A. 22:228

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USE OF COZYME* IN THE PREVENTION OF POST-OPERATIVE INTESTINAL ILEUS.

A COMPARISON STUDY

ELMER E. HAGUE, JR., M. D.
Spartanburg, S. C.

D-pantothenyl alcohol is proving to be another valuable weapon in the treatment and prevention of postoperative paralytic ileus.^{1, 2, 3} As a vitamin, its importance to the animal body was first noted in 1940⁴ when the deficiency syndrome in the dog, including nausea and vomiting, was described. This complex symptomatology suggested a disorder of the parasympathetic nervous system. A few years later⁵ a similar pantothenic acid deficiency study in rats revealed distention of the small bowel and absence of all peristalsis. If pantothenic acid was given before death, the animals recovered completely.

Lipman, 1948,⁶ discovered that coenzyme A is a pantothenic acid derivative just as cocarboxylase is a thiamin derivative and coenzymes I and II are niacin derivatives. As such, it has been shown to include an amazing number of synthetic reactions including the acetylation of choline, a necessary process for maintenance of normal bowel tone.

Perhaps of equal importance for understanding the use of d-pantothenyl alcohol in postoperative ileus is the work of Severinghaus and Rubin⁷ who have shown that there is usually an increase in the urinary excretion of the B vitamins, including pantothenic acid, following an operative procedure.

Method of Study

One-hundred patients undergoing a wide variety of surgical procedures were used for the control study. They were observed for return of bowel function following surgery. Peristalsis and passage of flatus or

The writer has found Cozyme to be a most valuable agent in prevention of postoperative paralytic ileus, both in abdominal and other surgery. The substance has no ill effects and has proven most useful.

feces were used as guides in this study. In addition, time intervals necessary for continuance of intranasal gastric intubation were noted. Those surgical patients undergoing procedures which were not abdominal, such as venous stripping, subtotal thyroidectomies, etc. were observed for signs of ileus since the stress of anesthesia and surgery may produce an ileus on the basis of urinary excretion of the vitamin rather than the reflex paralytic ileus which may follow manipulation of the bowel.

When the control study was completed a similar study was run on one hundred patients undergoing similar surgical procedures who received Cozyme in the immediate postoperative period. The dosage was 2 ml. (500 mg.) immediately following surgery, repeated again two and twelve hours later.

Results

Those patients receiving Cozyme had return of intestinal motility 0-6 days sooner than the controls. In the young age group where minor abdominal procedures were performed, there was little difference between the control and non-control patient, bowel function returning within 24 hours. In the older age groups where the surgical procedures were of a major nature, those patients receiving Cozyme displayed a striking difference when compared to the controls. Peristalsis returned 0-6 days sooner and the period of nasogastric intubation was considerably shortened. In about 40% of these patients the spontaneous passage of feces occurred before enemas were given. This usually occurred on the third or fourth postoperative day.

*Cozyme—trade name of d-pantothenyl alcohol kindly supplied by Travenol Laboratories, Incorporated, Morton Grove, Illinois.

Abdominal distention was found in six of the Cozyme cases but was of a minor degree. In contrast, 25 of the control group had distention, eight of these developing a severe ileus necessitating colon tubes and continuance of gastric suction up to eight days. One patient receiving Cozyme who was operated upon for acute suppurative appendicitis, had return of peristalsis and passage of feces despite copious drainage of pus from the operative site lasting up to ten days.

Five patients receiving Cozyme in the immediate postoperative period later reported that they no longer felt the need for cathartics, although each had been habituated to cathartics for many years.

Very little intestinal atony was noted in the patients whose surgical procedures were extra-abdominal. It was observed that while peristalsis returned at about the same time following surgery, pantothenic acid lessened the need for agents which help in the elimination of feces. Bladder catheterization tended to be less when Cozyme was given.

There were no reactions noted in any of the patients receiving d-pantothenyl alcohol. In no instance was it felt that any undue stimulus to the bowel had occurred, and cramping-type pains were non-existent.

Discussion

Paralytic ileus is a distressing problem in postoperative patients. Zollinger⁸ raises the question of gastrostomy in those patients where the need for gastric intubation may be prolonged, since the discomfort of these tubes remains long in the patient's memory. Not only does the patient complain of discomfort from the nasogastric tubes, distention, and frequent intravenous fluids, but the morbidity is increased from the physiologic disturbances that accompany ileus. Respirations are affected in that diaphragmatic excursions are limited by the abdominal distention. There is functional loss of blood into the interstitial vessels and an extracellular deficit since this fluid is drawn into the lumen of the atonic bowel. The distention created in the bowel results in concurrent nausea and vomiting with additional losses of fluid and electrolytes. Enemas, if retained at this time, add to the distention.

Naturally, the more rapid the return of

bowel function, the less physiologic disturbance is apt to occur. Following a brief period of atony and return of bowel function, fluids drawn into the gut return to the extracellular spaces. Fluids may be taken orally, lessening the need for intravenous feedings and corrections of electrolyte imbalances. Further, the drug decreases the necessity of venesection in those debilitated patients with poor veins.

In this study it was found that Cozyme definitely shortened the period for intravenous fluids and intubation by speeding the return of bowel function. This is particularly noticeable in the older patient undergoing a lengthy and major surgical procedure. The elderly patients, particularly those with chronic pulmonary disease, or other chronically debilitating states, are more apt to have a mild to moderate deficiency of all the vitamins. These are the patients in whom gastric and colonic tubes are routine procedures since ileus may manifest itself for many days. Since d-pantothenyl alcohol is not a stimulant to the bowel it may be used freely, even when intestinal anastomosis has been performed.

Summary

1. One-hundred patients undergoing a wide variety of surgical procedures were studied for return of bowel function. Another one hundred patients were studied in a similar manner, but in addition received Cozyme in the postoperative period.
2. The return of intestinal motility was shortened by 0-6 days in those patients receiving Cozyme.
3. The need for intranasal gastric intubation and intravenous fluid therapy was considerably shortened.
4. No reactions were noted in any of the patients receiving Cozyme.
5. Cozyme may be given freely, even in those patients undergoing an intestinal anastomosis, since it is not a stimulant to the bowel.
6. Five patients who received Cozyme in the postoperative period volunteered information that cathartics, to which they had been habituated, were no longer required. A long term follow-up study has not been made.

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MAMMALIAN BITES

KARL MORGAN LIPPERT, M. D., F.A.C.S.
Columbia, S. C.

The supersonic pace of men and things today is too great to spend time in consideration of such an ordinary item as an animal bite, but I warn you, the consequences of a neglected wound of mammalian origin can be just as morbid, if not mortal, as our most modern gadget for destruction of life or limb.

During the winter training period for race horses, we hear of stable boys and riders being bitten by their charges. Most of these bites involve the hand, foot or shoulder and because these parts are usually covered by clothing, the bites are seldom serious. On the other hand, because of his powerful jaws, a horse is capable of inflicting dangerous wounds of a tearing nature involving skin, muscle and bone.

In rural areas, seldom a "butchering time" goes by without a number of farmers being rushed to the hospital because they were bitten by a hog, fighting for its life. Because of the circumstances, these hog bites vary from simple lacerations, as though made with a sharp knife, to some of the most hideously mutilating wounds imaginable. The angry hog attacks in a series of rapid rushes in which his sharp, curved tusks rip and lacerate skin,

When man is bitten by man or by an animal, infection in the wound is the most likely sequel. Although each mammal bite may have peculiar characteristics, the basic principal in the treatment consists of intensive washings with soap and water, debridement, and simple gauze dressing. Delayed wound closure in most instances is advisable. Although many bacterial organisms have been found in various bite wounds, it appears that the infrequently cultured *Pasteurella* family are the significant organisms to be found in this type of wound infection. The wide distribution of *Pasteurellae* in mammals is presented in chart form with notes on the appearance and cultural characteristics of this bacterial family.

muscle and tendon. The wounds are usually heavily contaminated by filth and soil bacteria.

Nearly a half million people in the United States report that they have been bitten by a dog each year. Probably an additional one tenth that number are bitten under circumstances that do not seem to warrant official record. Dog bites vary from simple puncture wounds to irregular jagged lacerations. In the far north, Alaska, and other areas where dogs are beasts of burden, these half wild animals frequently attack children or persons in isolated places. The wounds, if not mortal, are horrible to see. Those who survive are disfigured and often heal with distorted bodies due to extreme cicatrization.

Human bites come from two principal sources; self-inflicted and those incurred in brawls. It is not uncommon in mental institutions to see persons nervously chew and suck

From Veterans Administration Hospital Columbia, South Carolina. The statements and conclusions published by the author are the result of his own study and do not necessarily reflect the opinion or policy of the Veterans Administration.

Presented at the Annual Meeting of the South Carolina Chapter, American College of Surgeons, in Columbia, S. C., November 1959.

Note. Dr. Lippert is now Area Chief of Surgery, Veterans Administration, Columbus, Ohio.

their fingers, causing maceration and infection. In street brawls, the index and middle fingers are frequently injured as the bare fist strikes an opponent's teeth. Sometimes, when the fighters are in close contact, one adversary will lock his teeth in his opponent's nose, ear, or cheek. Monkey bites resemble human bites and usually are seen among attendants in laboratories and zoological gardens. Gloves are usually worn by these attendants and bites are seldom reported except when there are wound infections.

Most people who report a cat bite have really been scratched. The typical cat bite is a group of small puncture wounds of the skin of the hand or face. Although the original bite may be hardly noticeable, in a few days it is followed by a local abscess that heals slowly, with marked edema and, if near a bone, osteomyelitis is common.

In 1948 the City of Baltimore, as a public health project, began to require the reporting of all rat bites. Usually the rat bite consists of one or two puncture wounds on an exposed skin surface. On the other hand, it has been said that a rat may attack a sleeping child and bite away considerable portions of flesh. Reporting rat bites in Baltimore was intended as a check on the rat population but most rat bites were reported from areas known to have a lesser rat infestation.

Prognosis

Whether the wound resulting from a mammalian bite is large or small, the prognosis is not dependent upon the extent of trauma, but rather upon the bacterial contamination of the wound. Tetanus is always to be feared and *B. Welchii* is not unlikely in domestic animal bites. Dog bites always carry the stigma of rabies, but only a small number of dogs who bite, do it because they are rabid. It has been mentioned that a cat may bite a person after it has devoured a part of a rat infected with the spirochete *morsus muris* and thereby transmit a form of "rat bite fever". In that connection, there are apparently two types of "rat bite fever", which are clinically similar but with different bacteriology. Sodoku (Japanese, which means rat poison) by culture shows a spirochete, identified as *morsus muris* or *Borrelia muris*. On the other hand, a mycotic rat

bite fever has been found to result from infections by *Actinomyces muris*, *Streptobacillus moniliformis* or *Haverhillia multiformis*. Typically after the bite of the infected rat an incubation of from two to thirty days may pass, when the apparently healed wound again becomes tender followed by the characteristic generalized disease process. The rat bite is also associated with the bubonic plague. Although the rat is not the transmitter of *P. pestis*, he is the host to the flea, *Xenopsylla cheopis*, which infects man through the flea bite.

Management

Opinions differ as to proper management of all mammalian bites. All sorts of cauterizations have been practiced during the ages. These are of little value. Where specific diseases such as rabies and tetanus are of concern, specific antitoxin or antigen should be administered. Otherwise debridement of all ragged devitalized tissue should be followed by scrubbing with liberal amounts of soap and water. Where wounds are extensive, the wound edges should be approximated only loosely and roughly. A cosmetic wound closure should be reserved for only the unusual case as a primary procedure, but rather carried out after all evidence of infection has subsided. A massive hot wet pack is the wisest form of early dressing. Study has produced a rather startling finding in regard to infection in mammalian bites. It is true that from time to time Vincent's organisms, Friedlander's bacillus, staphylococcus albus and aureus, streptococci both anaerobic and aerobic, and many spirochetes and fusiform bacilli have been found in pus of animal bites which were believed to have a casual relation to the infection. It has been determined that few of these are really pathogens but rather follow the invasion of a more insidious member of the group Pasteurellae. Smith and Conant¹ cited an instance of 66 cases of *Pasteurella multocidia* infections in human beings. One-half of these cases showed definite contacts with animals. They included 21 cat bites, 4 dog bites, 1 rabbit bite and 1 panther bite. The remaining five or six had been exposed to the carcasses of cattle, pig or rabbit. It was the opinion of those workers that many human pasteurella infections occur,

other than those manifested by local infections following animal bites. The illness is incorrectly diagnosed as influenza, inasmuch as the clinical symptoms of both diseases have a similar character and the pasteurilla group of bacteria have a superficial resemblance to *H. influenza*. This brings us to a description of the diseases common to man, produced by identified members of the pasteurilla group of bacteria, briefly summarized in the following table.

Pasteurellae are aerobic but can be cultured as facultative anerobes. The temperature range for growth ranges from 0° to 42° Centigrade but it is most profuse at 28° C. On plain or blood agar, after 24 hours incubation, the colonies of bacteria are small, round, glistening, transparent, colorless and umbilicated with rough edges. No true hemolysis occurs in blood agar but a surrounding darkened ring can often be seen about a colony. After four or five days growth, the colonies are mucoid due to development of capsular material. In broth cultures, when covered with a layer of oil, stalactite is characteristic but not diagnostic because some strains fail to grow

Figure 1
PASTEURELLAE KNOWN TO BE PATHOGENIC FOR MAN

Bacterial Identification	Habitat
1. <i>P. tularenensis</i> (ulceroglandular fever)	Rodents and fowls
2. <i>P. pestis</i> (bubonic plague)	<i>Xenopsylla cheopis</i> (rat flea)
3. <i>P. pseudo-tuberculosis</i>	Guinea pigs, rabbits and mice
4. <i>P. hemolytica</i>	Cattle and sheep (pneumonic)
5. <i>P. multocidia</i>	See Figure 2

The following additional infections, although not common, have been known to have been transmitted to man from animals as is indicated in the following chart. It is to be observed that this group make up a sub-list under 5 in the first chart.

in this manner. Further cultural characteristics show that nitrates are reduced to nitrites, hydrogen sulphide may show a small amount of indol production and gelatin is not liquified. Loeffler's media is not liquified by pasteurellae and they do not show coagulation of acidulated litmus milk. Also it has been noted that pasteurellae do not form gas in cultures

Figure 2
PASTEURELLAE MULTOCIDIA

Bacterial Identification	Habitat
Avicidia, *aviseptica, cholera gallinarum	Fowl (cholera)
*Boviseptica, <i>P. septica</i> , bollingeri, vituliseptica	Domestic cattle
Bubaliseptica	Buffalo (Barbone)
Cuniculicidia, *lepiseptica	Rabbits
Equiseptica	Horses
*Muriseptica, muricidia	Wild rats
Quiseptica	Sheep
Suilla, *suisieptica, suicidia	Swine
Feliseptica	Cats
Caniseptica	Dogs

*Ordinarily not considered as communicable to man but some rare human infections from this group have been reported.

Pasteurellae are frequently missed in ordinary smears of pus from wounds because of their pleomorphism, often resembling excessively decolorized cocci in Gram stain smears. A more complete description of their morphology and cultural characteristics follows as an aid in their identification.

containing glucose, maltose, lactose, manite and salicin, even after ten to fifteen days culturing. Morphologically, pasteurellae are short, plump rods, 0.5 mm. in width and 1.5 mm. to 1.75 mm. in length. The bacilli occur singly, as pairs and in short chains. They are pleomorphic, being more pronounced in older cultures. Bizarre forms can be produced in forty-eight hours on plain agar if sodium chloride is added. The

organism is non-motile and non-spore forming. It is Gram negative and shows bi-polar staining when the smear is air dried and alcohol fixed.

Fortunately, it has been found that our common antibiotic preparations are very effective in control and cure of all of the pasteurellae infections. It was demonstrated in 1946 that streptomycin was almost specific against tularemia. Later it was found that aureomycin, (tetracycline) followed by terramycin, (oxy-tetracycline) was most effective against all pasteurellae. It is probable that some of our more recent antibiotic preparations are just as effective or more so than aureomycin or terramycin.

Summary

When man is bitten by man or an animal, infection of the wound is almost the rule. Although each type of bite may have its peculiar characteristic, the basic form of treatment consists of intensive washing with soap and water,

debridement and simple gauze dressing. Delayed wound closure is advisable and only after all signs of infection have subsided under hot wet dressings. Most bacteria found in mammalian bite wounds are not pathogenic but various members of the pasteurellae group of organisms, although found as usual inhabitants of the apparently normal mammalian mouth, may be serious invaders of the tissues when entrance is gained through a bite. Fortunately, pasteurellae are sensitive to ready available antibiotics, which should be freely administered in all forms of mammalian bites.

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MURDER BY ASA (Aspirin)

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“**D**octor, I have been giving my child aspirin for a fever for four days and I just cannot break it. He now has a rash and I am just wondering if he has the measles. I think maybe you should see him.”

This is not an uncommon occurrence. In many cases the clinical course up to this point coincides with measles before the appearance of the rash. In this case the treatment with the aspirin has been perfectly satisfactory; however, in just as many cases the distribution of the rash, the appearance of the throat, and a throat culture yielding beta hemolytic streptococci, confirms the diagnosis of scarlet fever. In this instance it is ironic that one of the two drugs that is most beneficial to rheumatic fever is probably, in many cases, to blame for the occurrence of rheumatic fever and nephritis following a streptococcic infection.

The Pharmacological Basis of Therapeutics, by Goodman and Gilman, lists the following uses of salicylate: anti-pyresis, analgesia, relief of colds and grippe, uricosuric action in gout, and anti-inflammatory action in rheu-

The popular fallacy of the true efficacy of aspirin is deplored, and the dangers of reliance upon it as a cure are emphasized. Proper restrictions to avoid poisoning are advocated.

matic fever. However, preceeding the uses, the pharmacology lists undesirable side effects. In bold face type is listed ACUTE SALICYLATE POISON. Other undesirable reactions listed are skin eruptions, gastrointestinal symptoms, disturbance of the acid balance of electrolyte structure of the plasma, and hemorrhagic phenomena.

The following quotation is taken from the book noted above: ‘Salicylates are widely used in medicine and are indiscriminately employed by the laity for every conceivable ailment. When one considers that overnight a million pounds of aspirin alone are consumed yearly in the United States, the high incidence of toxic reactions to salicylate is not surprising. Fortunately, most of these cases are mild and inconsequential; however, salicy-

late poisoning can result in death and the drug should not be used as a harmless household remedy. Idiosyncrasy is also a cause of untold responses to salicylate. Furthermore, renal and hepatic insufficiency or hypoprothrombinemia enhances the possibility of salicylate poisoning when larger doses are ingested. Children with fever and dehydration are particularly prone to intoxication from relatively small doses of salicylate. . . . The majority of the properties attributed to salicylates by the laity and for which they are widely used have no existence in fact."

It is unfortunate that the anti-pyretic effect of aspirin has made it a cure-all for practically all diseases. By some unfortunate method, or methods, the vast majority of the population has been educated to think that all that is necessary to cure any disease is to lower the temperature. On the aspirin bottle or package, which is so readily obtained from the drug-store without prescription, the manufacturer has cautiously placed the words, "if fever persists, see your doctor". However, the dependence upon lowering the temperature as a cure-all, and the confidence that has been instilled in the public concerning the curative powers of lowering fever, obviates the necessity of the parents' observing this precaution.

Statistics as to the number of deaths caused indirectly by the use of aspirin are not obtainable. However, the idea that all that is needed to cure any disease is to bring the temperature down, doubtless accounts for a vast number of deaths through the postpone-

ment of treatment of serious infectious diseases. Further, and probably of more significance, this dependence upon aspirin as a cure-all probably accounts for a greater number of cripples due to rheumatic fever, heart disease and nephritis because of inadequate treatment. The side effects of salicylates as listed by Goodman and Gilman are, in my opinion, secondary to the number of deaths and cripples caused indirectly by the dependence upon aspirin, and the false feeling of security that is occasioned by lowering the temperature—Nature's agent for combatting infection.

In my opinion, there are far more reasons for aspirin being a prescription item than most antibiotics. I dare say that the number of deaths due to salicylate intoxication far exceeds the number of deaths due to penicillin or other antibiotics taken orally. The urticarial reactions of antibiotics, especially penicillin, may occur more frequently than those due to salicylates. However, if the patient has taken an antibiotic, there is a chance that he might be doing something to bring the infection under control; whereas using aspirin brings the temperature down and robs the patient of Nature's defense against infection and in many cases actually puts the patient in worse condition. At the same time, however, the patient has a feeling of security because he feels better with the temperature lowered.

It is my opinion, further, that salicylates should be made a prescription item and the indiscriminate use of aspirin be publicized under the caption "Murder by ASA".

PORTAL HYPERTENSION AND BLEEDING ESOPHAGEAL VARICES

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There are few conditions which present themselves as abruptly and as emergently as massive hemorrhage from esophageal varices. A physician confronted with this problem must institute measures immediately to control the hemorrhage and replace the blood loss. Many times these patients are too ill to have diagnostic studies such as an upper gastrointestinal roentgenogram done. Bed side diagnostic procedures must be relied upon heavily.

It is generally accepted that an increase in portal venous blood pressure is due to obstruction to the portal venous system. This obstruction may either be intrahepatic or extrahepatic. The intrahepatic variety accompanies the advanced stage of various disease processes which produce an abnormal histological pattern in the liver; a pattern characterized by hepatic cellular destruction and increased periportal fibrosis.¹ Many of the basic mechanisms are at present the subject of much investigation. There has been good evidence advanced that portal hypertension is due to sinusoidal outflow obstruction.² In the extrahepatic variety it is difficult to consider causes for the portal hypertension other than the mechanical obstruction provided by the obliterated lumen of the portal vein.¹ The portal vein obstruction is congenital in origin or due to thrombosis from various causes. Womack³ advanced the theory that arterio-venous fistulae in the submucosa of the stomach and lower esophagus might be responsible for portal hypertension. There has been much speculation as to the cause of rupture of these varices once they have formed. The two conventional explanations for hemorrhage are rupture due to increased pressure or rupture due to ulceration from esophagitis.⁴

At least 60% of patients having cirrhosis

Proper treatment of the patient who is bleeding massively from esophageal varices will salvage many of them.

Cirrhosis of the liver is the most common cause of portal hypertension. Extrahepatic obstruction of the portal vein, most often seen in children, is a less common cause. Approximately 60 per cent of patients having cirrhosis also have esophageal varices. Bleeding from varices accounts for 25 per cent of the deaths in these cirrhotic patients. About 50 per cent of the patients having hemorrhage will die during the first bleeding episode.

Diagnostic measures include roentgenograms of the esophagus, splenoportograms, and splenic pulp pressure. Control of the massive hemorrhage and replacement of blood are the first objectives. A Sengstaken-Blakemore tube with gastric and esophageal balloons is used to compress the varices. Following the initial hemorrhage, rehabilitation of the damaged liver must be instituted. Presence of associated hypersplenism must be evaluated. A definitive operation to decompress the portal venous system must then be done. The operation of choice is the anastomosis of the portal vein to the inferior vena cava. Other shunt procedures such as a spleno-renal or a caval-superior mesenteric are sometimes indicated.

Cases are discussed.

will have esophageal varices. Not all of them will bleed from these varices, however. Hemorrhage accounts for approximately 25% of the deaths in patients having cirrhosis of the liver. Of those having a hemorrhage, approximately 40 to 60% will die with the initial hemorrhage.⁵ The great majority of the survivors will probably die within two years from subsequent hemorrhage. Recurrent hemorrhage can be effectively prevented by adequate surgical decompression of the portal system.⁶

It is the purpose of this paper to outline the

emergency treatment for the massive hemorrhage, diagnostic methods available to differentiate hemorrhage due to varices from other types of upper gastrointestinal hemorrhage, rehabilitation of the patient and preparation for definitive operation following hemorrhage, and the operations available to decompress adequately the portal venous system.

Control of Hemorrhage

In the majority of patients bleeding from esophageal varices, the hemorrhage can be controlled with the use of a Sengstaken-Blake-more double balloon, triple lumen tube.⁷ This tube will decompress the varices in the cardia of the stomach and in the lower esophagus. The third lumen allows aspiration of the stomach. The flow of blood is usually reversed, coursing from the liver through the coronary vein, through the varices, and on into the azygos system. Inflation of the balloon in the stomach alone will often compress the varices adequately. Therefore, the tube is inserted, the gastric balloon is inflated, and

slight traction made on the tube to engage it in the cardia. If hemorrhage does not stop, the esophageal balloon is then inflated. Adequate instructions for use of these tubes accompany them. This tube serves as an excellent diagnostic tool as well as a therapeutic measure. If blood can be aspirated continually from the stomach after the tube is in place with both balloons inflated, it is probably coming from a source other than the varices. (Figure 1) If bleeding stops, it is our policy to leave the balloons inflated for a period of 24 hours and then to deflate first the esophageal and then the gastric balloon. If bleeding recurs, both balloons are then inflated for another 24 hours. Recurrent bleeding after deflation for the second time at the end of 48 hours is usually an indication for direct attack on the varices.

Direct transthoracic ligation of these varices is indicated when hemorrhage is not controlled by the use of the above tube. The chest is opened through the 7th or 8th intercostal space and the esophagus opened by a vertical incision in its lower end. The varices are oversewn with a continuous suture throughout their length. Many times these will extend into the cardia of the stomach making it necessary to extend the procedure to this area. The perforated varix can most often be found readily. This will provide adequate temporary control of the bleeding. This procedure must not in any way be construed as definitive treatment for bleeding esophageal varices. It should not be undertaken in the presence of such signs of hepatic failure as deep jaundice, a bleeding diathesis, confusion, or coma.

There are some clinics which have employed the emergency portal-to-systemic venous shunt to decompress the portal system. It is applicable only in very good risk patients who have adequate liver function. We have not used the shunt procedure for emergency treatment of these patients.

Diagnosis

History and physical examination will immediately give some indication as to whether or not a patient is bleeding from esophageal varices. A history of cirrhosis, jaundice, hepatitis, or prolonged alcoholic intake are all indicative of varices being present in the esophagus. Findings such as ascites, distended

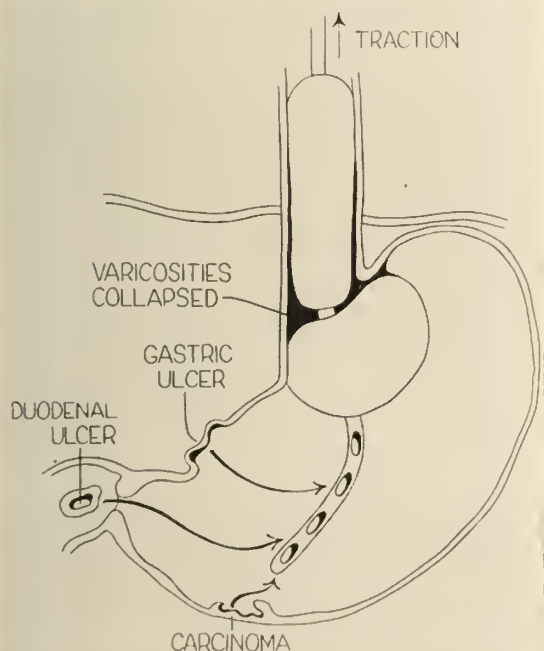


Figure 1

A double balloon, triple lumen tube properly placed in esophagus and stomach. Diagnostic as well as therapeutic value of tube demonstrated by detection of bleeding from other sources when varicosities are collapsed.

abdominal veins, jaundice, a palpable liver or spleen necessitate inclusion of portal hypertension in the differential diagnosis. As mentioned above, the double balloon, triple lumen tube is very useful as a diagnostic tool. After hemorrhage and shock have been controlled, a barium swallow can be done which will reveal varices in 80 to 90% of the cases in which they are present. The varices will give the lower end of the esophagus a rather ragged appearance with many filling defects. (Figure 2) Esophagoscopy has been effective-



Figure 2
Esophagogram demonstrating varicosities as filling defects in lower esophagus.

ly used but this can be a hazardous and unrewarding procedure in the patient bleeding massively from esophageal varices. It must be done by someone expert in its use, if it is to be helpful.

An emergency bromsulphalein (BSP) test is of great value in screening patients for liver disease and in separating from the group with acute gastrointestinal hemorrhage those in whom varices should be sought. Body weight is estimated and bromsulphalein is given intravenously in a dose of 5 mg./kg. Greater than

15% retention at the end of 45 minutes is considered to be a positive test. In a recent study of 95 patients in whom this test was done, there was but one false negative test.⁸ By this it is meant that one patient with retention of less than 15% at 45 min. was found to have varices. The presence of a positive test does not prove that varices are definitely present, but approximately 50% of the group with positive tests will be found to have varices when they are carefully searched for.

One of the most valuable diagnostic procedures is percutaneous serial splenoportography. It is essential that this procedure be done in order to locate the obstruction to the portal system preoperatively so that the proper surgical approach can be made. It consists of injecting a water soluble contrast media into the spleen with serial x-ray films taken one-half second apart. This can be done with local anesthesia in adults but a general anesthetic is necessary with children. An 18 gauge needle is inserted directly into the spleen. If the spleen extends below the costal margin, it can be inserted below the costal margin into the spleen. If the spleen is not palpable, the needle can be inserted in the 9th intercostal space in the posterior axillary line. It is necessary for the patient to be apneic for the few seconds that it takes to insert the needle. The needle should extend for two or three centimeters into the splenic pulp. If it is properly placed, there is a constant drip of blood when the stylet is removed. A short length of rubber tubing is inserted between the needle and the syringe so that the needle may move with respiration. The needle should not be kept stationary at any time that the patient is breathing because of the possibility of lacerating the spleen. The dye is injected rapidly and multiple film exposures are taken at the end of injection. The technique for this procedure has been well described.⁹ If careful attention is paid to the details of the technique, complications will be minimal. Visualization on splenoportogram of reflux into the major tributaries making up the portal vein, increased collateralization, and actual demonstration of esophageal varices are diagnostic of portal hypertension.

Figure 3 is a splenoportogram on a small



Figure 3

Splenoportogram demonstrating normal portal system without signs of portal hypertension.



Figure 4

Splenoportogram demonstrating extrahepatic portal vein obstruction with reflux of dye into the coronary and esophageal veins.

child who was suspected of having bled from esophageal varices. His splenic pulp pressure was only 200 mm. of water and his splenoportogram was normal. This child had an enlarged spleen and hypersplenism but this was not associated with portal hypertension. The spleen was removed and no shunt procedure done. The value of splenoportogram before operation is well demonstrated in Figure 4. This child had splenomegaly and hypersplenism and had bled massively from the upper gastrointestinal tract. His splenic pulp pressure was 350 mm. of water. The splenoportogram demonstrates very well a block in his portal vein with reflux into the coronary vein and into the esophageal varices. Because his portal vein could not be used, splenectomy combined with a splenorenal shunt was done. Figure 5 is the splenoportogram done on a child believed to have an extrahepatic portal vein block. As can be seen by the splenoportogram, there was an intrahepatic block with reflux into the collateral circulation. The coronary vein and esophageal varices filled readily. The splenic pulp pressure was 360 mm. of water. The splenoportogram is carried

out immediately before operation so that if there is any undue bleeding from splenic puncture it can be corrected at operation. We have had only one patient with a significant amount of blood in the peritoneal cavity at operation.

Splenic manometry, another useful adjunct in diagnosis, is combined with splenoportography. A high degree of correlation has been observed between the values of the pressure in the splenic pulp and the extent of portal congestion and collateralization.⁶ Panke, Rousselot and Moreno⁹ have used splenic pulp manometry as an emergency test in the differential diagnosis of acute upper gastrointestinal bleeding in 113 patients and have found it to be 90% accurate in the determination of the presence or absence of esophago-gastric varices in patients bleeding from the upper gastrointestinal tract. In all of their patients with the pressure in the splenic pulp over 290 mm. of water, bleeding was from esophageal varices. In all of their patients in which the splenic pulp pressure was below 250 mm. of water, the bleeding was from some



Figure 5

Splenoportogram demonstrating an intrahepatic obstruction with reflux into the coronary and esophageal veins and increased collateralization.

other site. There were only 11 patients with pressures between 250 and 290 mm. of water, four of whom were bleeding from varices and seven from some other site. We have not used this as an emergency measure to differentiate bleeding from other causes but in the elective cases we have found a good correlation between the splenic pulp pressure and the pressure in the portal vein at operation. A spinal fluid manometer is used and filled with normal saline. The manometer is connected to the rubber tubing and the bottom held 12 cm. above the plane of the table. This pressure can be taken just preceding the injection of the contrast media for the splenoportogram.

MEDICAL MANAGEMENT DURING AND FOLLOWING THE ACUTE HEMORRHAGE

Treatment of the Acute Hemorrhage

Patients who have bled from esophageal varices must face not only the problem of exsanguinating hemorrhage, but also the deleterious effect of the bleeding on an already diseased liver. Those individuals with extrahepatic portal block are an exception to this and will be discussed below. Therefore, as intensive medical treatment as possible should

be delivered to these patients once their hemorrhage has been controlled, whether it stops spontaneously, or whether the use of the Sengstaken-Blakemore tube has been necessary.

Vigorous blood volume replacement with the freshest whole blood available is necessary to combat the hypotension or shock. Since hemorrhage has been demonstrated to cause decreased hepatic blood flow experimentally in dogs,¹⁰ it can be assumed that the already diseased livers of the patients are subjected to deleterious anoxia if the patients are allowed to remain hypotensive for any period of time. Transfusions should be given liberally, and if any transfusion is indicated, these individuals should get at least a liter of blood. In the emergency situation, a colloid such as dextran is certainly not contraindicated.

Oliguria often accompanies liver failure. When this situation is encountered, one must consider the intake and output of fluid with the same care as is necessary in any other individual with decreased urinary output.

Clotting defects are also a part of the clinical picture of hepatic failure. Individuals may have increased prothrombin times even in the absence of jaundice. Therefore, a search should be made for a coagulation defect, and in so far as possible, if such a defect is discovered, it should be corrected. Bleeding time, clotting time, prothrombin time, and platelet counts should certainly be determined. Wherever possible, a fibrinogen level should be estimated. In the presence of a low prothrombin time, vitamin K₁ oxide (Mephyton) should be given slowly intravenously in 50 mg. dosages. If a low fibrinogen level is demonstrated, fibrinogen can be obtained from Red Cross Blood Centers and should be given intravenously in 2 to 4 gram dosage. Vitamin C, 500 mg. intramuscularly, should be given daily. The water soluble B-vitamins should be administered intramuscularly or intravenously to these patients after a hemorrhage. This is especially true in the alcoholic. There is no conclusive evidence that agents such as choline, methionine, concentrated crude liver, liver extract, etc. are beneficial in these patients. Their use is not contraindicated, however, and in the depleted alcoholic

with a liver infiltrated with fat, many physicians feel that such lipotropic agents are of therapeutic value.

The most feared complication of bleeding from the esophageal varices is hepatic failure with hepatic coma. Current thinking indicates that this syndrome is connected with the absorption of excessive quantities of the breakdown products of the blood from the gastrointestinal system. Its presence is usually indicated by the development of the alternating flexion-extension tremor when the extremities are held in extension which has been called the "liver flap". This physical sign should be sought for at least twice a day in individuals who have experienced a major hemorrhage from esophageal varices. Other signs are confusion, memory loss, mild stupor, incoherence, incontinence, and excessive drowsiness. Therefore, elimination of the blood from the intestinal tract is important. This is best accomplished with purges of either magnesium or sodium sulphate given by mouth and frequent cleansing enemas. An attempt should be made to wash any blood out of the stomach if it is there in large quantity.

The blood is digested in part by the action of normal intestinal bacterial flora. These organisms are best eliminated by the oral administration of neomycin and kanamycin in dosages in the order of 8 to 12 grams per day.¹¹ This medication should be given when blood is in the gastrointestinal tract or hepatic coma is present or threatening. Other antibiotics designated to sterilize the gastrointestinal tract are not as effective.

Many of these patients die of pulmonary infection. The presence of the esophageal balloon certainly tends to increase this hazard because of the possibility of aspiration. Prophylactic antibiotics are not as effective in preventing this complication as is intelligent nursing care. A special nurse is of very great value. These patients should be helped with expectoration. They should be turned frequently and encouraged to breathe deeply. If there are any signs of developing infection, this should be treated immediately and vigorously. The choice of the antibiotic is indicated by the character of the organism present in the sputum and the type of infection.

Catheters left inlying for more than three or four days will be followed by a urinary tract infection. Even though an inlying catheter is a necessity in many of these individuals, it should not be used unless necessary. Fever may be a sign of hepatic necrosis. Fever accompanied by very high white blood cell counts with a large percentage of polymorphonuclear leucocytes and hepatic tenderness is suggestive of active hepatic necrosis. This picture is also accompanied by increasing jaundice usually.

Especially in the alcoholic, some form of delirium is not uncommon. One must balance the necessity for control of this delirium against the fear of oversedating these patients and precipitating them into coma and thus exposing them to all of its complications. Agents such as the phenothiazines are probably better used here than large doses of the barbiturates. Meperidine, morphine and Levo-Dromoran should be used with great care. There is no contraindication to the use of barbiturates, but running orders should not be written and the patient should be carefully evaluated before each dose. The same is true of paraldehyde.

Rehabilitation Following the Acute Hemorrhage

The hazards of exsanguinating hemorrhage, hepatic failure, and infection will cause the death of many individuals with severe hepatic disease who bleed from esophageal varices. Those patients who survive the acute phase continue to need careful management.

Bed rest in the hospital is of great value in the care of individuals with chronic liver disease. This simple therapeutic technique is perhaps the most difficult to administer. As long as the patient is showing improvement but remains with a tender enlarged liver, every effort should be made to keep this individual from working. These people should be given a high caloric diet containing adequate amounts of protein and large quantities of carbohydrate. Some patients with badly compromised livers will not be able to tolerate as much as 100 Gm. of protein a day, but most patients can and should be given this much. Vitamin supplementation is indicated. In the

alcoholic, absolute withdrawal from alcohol is mandatory. The period of rehabilitation should last until a patient fails to show further signs of improvement. If an operation is contemplated, it must be remembered that this is a formidable procedure and the patient should be in optimum condition for it. Follow up, however, should be close enough so that the patient does not escape long enough to have another hemorrhage.

In a selected few patients, esophageal varices have been demonstrated to disappear under so-called conservative medical management. Also, varices have been demonstrated in the presence of acute hepatic disease. It should be stressed, however, that this is unusual, and any patient who has survived a single hemorrhage, whether major or minor, from esophageal varices should be considered a potential candidate for a portal to systemic venous shunt. For many reasons, many of these patients will not be suitable for operation, but all should be evaluated with this in mind.

FACTORS IN SELECTING PATIENTS FOR OPERATION

Previous experience with large numbers of cases has divided these patients into two groups. The first of these is the group with extrahepatic portal block who have no liver disease. These individuals characteristically have many hemorrhages and survive them uneventfully. This is a relatively uncommon syndrome. It should be suspected in younger persons who are bleeding from varices and in those individuals who have no history of any liver disease. The presence of this blockade of the portal vein extrahepatically is best proven by splenoportogram which has been discussed above. Any of these individuals who have varices and who are of sufficient age should have a surgical attack on the portal venous system.

The group with intrahepatic portal blockade are those with portal blockade secondary to liver disease and can be further divided into three more classes as far as operation is concerned. The first of these contains the inoperable patients. These are individuals with deep jaundice, advancing liver disease, ascites,

and peripheral edema. This group of patients has very little chance of surviving a procedure. They are the group whose liver disease is so advanced that their death will probably result from hepatic failure before they have a chance to bleed to death. The salvage rate of such patients is so low at this stage of the disease that operation must be postponed in the hope that they will improve to fall into one of the lower risk groups.¹²

In decreasing order of importance, the following factors have been shown to affect the mortality rate of portacaval shunt: ascites, edema, jaundice, hypoalbuminemia, prolonged prothrombin time, high bromsulphalein retention, a highly positive cephalin flocculation test, hepatomegaly, and the presence of spider angiomas. The more obvious any one of these signs is, and the more of them that are present, the higher the mortality rate will be. In the class which falls into the high risk category, e.g. those with very large livers, serum albumin of just 3 Gm. per cent, mild jaundice (bilirubin less than 2 mg./100 ml.), BSP retention over 10%, a 3 or 4+ cephalin flocculation test, and minimal edema but no ascites, the mortality rate is approximately 30%. If the liver disease in these patients is stabilized, and has been so for a period of time, and they have survived one hemorrhage but obvious varices remain in the esophagus, most writers feel that this is an acceptable risk to take. These patients should be subjected to operation once they are made aware of the implications of their situation. The good risk group has none of the above signs present. These are people with a better hepatic reserve, stabilized liver disease, definitely present varices, and the history of one hemorrhage. In this group the operative mortality rate is approximately 10% and certainly operative therapy is indicated.

The medical care of these individuals does not end with their operation. The operation is designed only to protect them from the single hazard of exsanguinating hemorrhage. Therefore, once the operation has been successfully completed, they should be followed medically with careful attention to such details as adequate rest, adequate diet and abstinence from alcohol and vitamin supplementation.

OPERATIONS

After the patient has been prepared for operation, the procedure should be delayed no longer because of the possibility of recurrent hemorrhage. Two of our patients have bled severely in the hospital on the day prior to scheduled operation. A procedure must be done which will attain protective decompression of the portal system. The portal blood pressure should be reduced below 250 mm. of water for prevention of recurrent hemorrhage.

At the present time, the most effective procedure for decompressing the portal system and preventing subsequent hemorrhage is the anastomosis of the portal vein to the inferior vena cava.^{1, 2, 6, 13, 14} The advantage of this procedure is that both veins are large and thick walled so that a large shunt measuring over 1 cm. in diameter can be accomplished. The incidence of postoperative occlusion of this shunt from thrombosis is low. Decompression is effective and recurrent bleeding after shunt is infrequent. Although this operation is now generally accepted as the most effective one for preventing subsequent hemorrhage, there is considerable controversy as to the method of construction of the shunt. Whether or not to divert all of the portal blood by a direct end-to-side portacaval shunt or only a portion of it by a side-to-side shunt is the point at issue. The advantage of the end-to-side portacaval shunt is that all splanchnic blood collected in the portal vein is delivered directly into a lower pressure system, effecting maximal decompression.^{6, 13} Longmire¹ favors the side-to-side anastomosis because it preserves the normal pathway of the portal blood to the liver. He believes that there is some evidence to suggest that, with the transient changes in portal pressure associated with normal activities, a portion of the portal blood may intermittently pass beyond the shunt into the liver, and that this may, in part, be responsible for the satisfactory results obtained. Warren and Muller² also favor the side-to-side portacaval shunt but for a different reason. They present evidence to show that the overall hemodynamic effect in cirrhosis is a post-sinusoidal outflow obstruction which leads to an elevation in the hepatic sinusoidal pressure. As this increases, the sinusoidal pressure ex-

ceeds the free portal vein pressure and leads to a spontaneous conversion of the portal vein to an outflow tract from the liver. Therefore, it is their feeling that the side-to-side portacaval shunt is desirable as it preserves the portal vein as an outflow tract from the liver for decompression of the intrahepatic sinusoidal hypertension which is present.

Suffice it to say, that both types of portacaval shunts have given very good results in decompressing the portal system. There are many more details of the controversy between the best method of establishing this shunt which do not warrant discussion here. Rousselot, Moreno and Panke¹³ reported no incidence of postoperative bleeding from ruptured varices in a series of 45 end-to-side portacaval shunts. They also found that the circulation of the portal blood through gastroesophageal varices or other collaterals was no longer observed in splenoportograms after the establishment of a direct end-to-side portacaval shunt.

The splenorenal shunt enjoyed a certain amount of popularity for a while but the disadvantages of this shunt, so well cited by Partington,¹⁴ have caused most clinics to give it up. The wall of the dilated vein may be excessively thin and there may be little of it beyond the tail of the pancreas. Mobilization of additional splenic vein is time consuming because of the numerous thin wall tributaries from the pancreas. Sharp angulation between splenic and renal veins may occur. The incidence of postoperative occlusion of the splenorenal shunt with subsequent hemorrhage is much higher than with the portacaval shunt. The splenorenal shunt has its place in cases in which the portal vein itself is obstructed and can not be used for a portacaval shunt. It also has its place in certain cases in which there is a rather marked hypersplenism in which it is necessary to remove the spleen.

Other procedures have been utilized especially when neither the portal nor splenic veins are satisfactory for construction of a shunt. Clatworthy and Boles¹⁶ have described and used a shunt between the superior mesenteric vein and the inferior vena cava in children. Resection of the varix-bearing area in the proximal stomach and distal esophagus

can be done if there is no other alternative.

Shunt procedures in children, especially those below ten years of age, have proved quite disappointing. The problems have been well brought out by several authors.^{15, 16} The problems revolve around the facts that the veins with which shunts can be constructed are small and thin walled, making shunts of adequate caliber almost impossible. Fortunately, many of these children have an extrahepatic obstruction without liver damage and can tolerate many bleeding episodes very well. Direct ligation of the varices often offers significant palliation. This can be repeated as necessary until the child is old enough to have a venous shunt constructed which will be large enough to decompress effectively the portal system and remain patent.

Summary

Management of patients having esophageal varices complicated by acute hemorrhage includes emergency treatment to control the hemorrhage, rehabilitation following cessation

of hemorrhage, and definitive operations to prevent recurrence of hemorrhage. When this cannot be accomplished, many of these patients will die with the first or subsequent hemorrhages. The theories concerning etiology of portal hypertension are cited. The hemorrhage must be controlled by compressing the varices with a double balloon, triple lumen tube or by direct ligation of the bleeding varices. Diagnosis should include barium swallow, liver function studies, splenoportography, and splenic manometry. Other causes for gastrointestinal hemorrhage must be ruled out. Medical management during and following the acute hemorrhage is extremely important as there are many problems associated with these severely ill patients, especially that of marked liver disease. The patient must be rehabilitated to as healthy a state as possible prior to operation. Factors used for selecting patients who will benefit by a definitive operation are given. The definitive portal to systemic venous shunt operations which will lower the pressure in the portal system are discussed.

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MEMORIES OF A BUSY LIFE

WILLIAM WESTON, M. D.

Columbia, S. C.

I moved to Columbia, South Carolina on January 1, 1897 and began a general practice of medicine. Among the physicians who were practicing here at the time I moved to Columbia were Drs. A. N. Talley, T. M. DuBose, B. W. Taylor, L. K. Philpot, W. M. Lester, Strother Pope, Oliveras and Sylvester, and arriving just before 1897 was Dr. A. B. Knowlton and during 1897 Dr. Joseph J. Watson, Dr. E. M. Whaley and Dr. R. W. Gibbs.

Columbia at this time was a small unkempt city of fewer than 18,000 people. As it had no paved streets nor sidewalks, in rainy weather the mud was so deep on many of the main streets that it was difficult to drive over them and in dry weather there were clouds of dust. These were typically horse and buggy days.

There were a few enterprises, such as small factories and fertilizer plants on the outskirts of the city, which gave employment to quite a number of people. These developments were followed by the building of cotton mills which increased considerably the population of the city. The mode of transportation in the city was by street car, drawn by mules.

The prevailing charges by physicians were \$2.00 for a house visit and \$1.00 for an office visit. These fees, considered now utterly inadequate, were pronounced exorbitant by many at this time, and were seldom paid in full. The health conditions in and around Columbia at this period were far from satisfactory. Typhoid fever, malaria and uncinariasis were common. Then the population was increased by people coming in from the rural districts the health of these people was appalling. Many of the families were stricken by uncinariasis. I had so few private patients that in order to occupy my time and to make some contribution to the welfare of the community I established free clinics, among them a hookworm clinic where hundreds of patients were treated and restored to active life. I distinctly recall that my friend, Mr. W. B. Smith-Whaley the founder and president of several cotton mills, was so alarmed by conditions that he called on me to make a survey

and do what I could to improve conditions in the cotton mill villages. I asked him to accompany me on an inspection trip in the newest of the mills, the Olympia. Our first inspection was of a reservoir filled with water from which he expected to supply a mill village of several thousand people. There was a strong smell of sulfuric acid in the water and I told him that previously there had been a sulfuric plant a few hundred yards from the reservoir and the smell was coming from that source. He said, "Well, what will happen to the people if they drink this water?" and I said "They will die." He thought I was mistaken and said he was going to get a number of fish and put in there and see what would happen to them. I told him that the fish would die promptly, and sure enough, they did. This convinced Mr. Whaley of the unsuitability of his reservoir for drinking water and it was abandoned in favor of the city water supply. Following this he was also shown certain pools of water from which great numbers of mosquitos were coming. I told him that these pools must be either drained into the river or kept oiled, but the drainage was far cheaper. When these, and many other changes, had been made and the hookworm treated, the mill villages became thriving communities.

My interest in hookworm was aroused by an incident in which the Judge of Probate had requested me to examine a man in the Olympia Mill village for insanity. When I saw this man I talked with him and observed his appearance and that of his family. My mind quickly reverted to a description given by Dr. Arthur Loos of the British Medical Service. Dr. Loos and Dr. Symmers were ordered by the British Government to proceed to Egypt (Dr. Symmers was the bacteriologist and pathologist who accompanied Dr. Loos on the assignment to Egypt) to ascertain why the fellerheen were so lazy that they would not work. A thorough but rapid survey was made and it was discovered that they all had uncinariasis. The pictures drawn by Drs. Loos and Symmers were so vivid and

so accurate that it made an indelible impression on my mind that I reported to the Judge of Probate that this man was not insane, but was suffering from uncinariasis, as were all of his family and that the disease could be easily cured and the family could be restored to useful occupation in a short time. I reported this experience to Mr. Whaley, the president of the mill, and he asked me what to do about it. I told him that we needed to start a clinic there and treat the disease on a wide scale, as I had no doubt but that there were a great many cases in the village. Mr. Whaley was so impressed that he approved and requested that I proceed with the work, which I did with the result that more than 1,500 cases were found, examined and treated.

In the early days of my residence in Columbia, there was only one hospital here—a small affair conducted by the Ladies Auxiliary, and a patient admitted there was under the supervision and in the name of a member of the staff. This did not meet with kindly reception by the more ambitious younger members of the profession and, consequently, operative procedures were done not unusually in the homes on the kitchen table.

An amusing incident occurred in the presence of several members of the younger physicians on an occasion in which a very strong robust Negro man was to be operated on for a mastoid infection and the anesthetist announced to the operator: "Doctor, your patient is under the influence of the anesthetic and is ready for your procedure," whereupon, the operator, the mallet and chisel in hand, began his work. The man called out "Who dat knocking at my door?" The operator requested the anesthetist to give more ether. In a short time the anesthetist again announced: "Doctor, your patient is ready," whereupon the operator with chisel and mallet in hand, began again. The darkey raised up and said: "Ain't you hear me ask you who dat knocking at my door?" The operator called for more anesthesia and in a short time the anesthetist said again: "Doctor, your patient is ready." Again the chisel and mallet were brought into play with the result that the

darkey jumped from the table and fled and was not seen again for several hours.

During the hookworm campaign it was reported to me that one of the children of a family which was under treatment had discovered a nail which had been driven in a tree in front of the house. This infuriated the father, who announced that his next door neighbor had driven the nail in the tree in order to put a "spell" on his household. A fight ensued between the heads of the two households in which both were badly punished, but after some kindly friend drew the nail from the tree the incident was forgotten and forgiven.

On still another occasion which might illustrate how diversified was the professional advice which was sought, a huge hefty woman came in and reported that her husband was drinking heavily, that his pay was consumed in the purchase of whiskey, and that she wished me to advise her what to do about it. It seems that at this time the weather was bitterly cold and I told her that the next time that he came in drunk to have his clothes removed, get three or four of her strong women neighbors to help put him in a tub of cold water and to pour one bucket of cold water over him after the other until he begged for mercy and gave a solemn promise to no longer drink. This poor creature was so miserable that one could hear his screams for a quarter of a mile. He begged for mercy, but the women held tight to their jobs and prevented his removal from the tub. He promised in the presence of a number of neighbors who had been attracted by his screams, that if they would desist from punishment, he would never touch another drop of whiskey and would bring his payroll check home to his wife. When the administrators of this punishment were satisfied that the sufferer meant what he said and would lead a new life, he was released from the tub and allowed to walk, although perfectly naked, into the house, where a huge fire awaited him and some friends dried him off. I was subsequently told that he had kept faithful to his vows never to drink again and his wife assured me that he brought his payroll check home and gave it to her.

While the services of the hospital were

closed to us younger members of the profession, it was not unusual for some of the older members to call upon their younger friends to pay visits for them. The fee for a house call was \$2.00, which if collected, was invariably turned over to the physician who had called upon the younger physician to pay the visit. I do not recall that it had ever been my experience or those of others who happened to mention the matter to me that the older physician ever offered any compensation or any part of compensation.

During those lean days it was fortunate for me that my name was suggested for several corporations as physician. With Dr. Joseph J. Watson, I served alternate months at the University of South Carolina Hospital (Wallace Thompson Memorial Hospital) and was examiner for several life insurance companies. Upon the death of Dr. Robert D. Earle, I became local surgeon of the Seaboard Air Line Railroad and was made surgeon of the Columbia Electric Railway Company. From these various sources, my income was increased beyond what was derived from private patients.

During my early years of practice I became more and more interested in diseases of children, a newly recognized specialty which constantly gained more importance as information accumulated under the great leadership of such men as Jacobi, Rotch, Holt and Abt. About 1907 I began to be more impressed with the scanty information available in the treatment of children and in the latter part of that year I became convinced that I would dedicate the rest of my professional life to the study and treatment of children. At that time the Children's Hospital of Harvard and The Babies Hospital of Columbia Universities, along with Chicago in the West, were considered to offer the best opportunities for study. Therefore I decided to start my work at the Children's Hospital at Harvard University under Dr. Thomas Morgan Rotch and his able staff, and then went to The Babies Hospital of Columbia University in New York under Dr. L. Emmett Holt. I was profoundly impressed at Harvard with how much there was to be learned and how little I knew of the subject. Upon finishing the course there and

after a brief visit home, I went to Columbia University and studied at the Babies Hospital in New York where I spent the mornings with Dr. Holt in his bedside visits and lectures in the afternoons at Ward 5 at Bellvue in charge of Dr. LaFetra, whom I found to be a great clinical teacher with a great abundance of material for clinical demonstration. I was deeply impressed at these several places by how much was known about children, but more especially about how much there was to know. Consequently when the Pediatric Department was established at Johns Hopkins, although I had been practicing only pediatrics for several years, I paid a visit to this department which had been newly established and had gained quite a reputation. At this time Dr. Howland was in charge and his bedside clinics were always interesting and instructive. He was a great teacher and a serious student of pediatrics.

After limiting my work to pediatrics, I have never regretted the step. Since 1908 my work has been limited to pediatrics entirely.

In regard to my post-graduate studies, I was most impressed by the experience I had through an incident in making rounds of the ward with Dr. LaFetra, who seemed depressed by the high mortality rate of children suffering from intestinal diseases. So many infants and children dying of infectious diarrhea! When an intern who was present and heard Dr. LaFetra express his concern, remarked that he had read in a German medical journal about the great benefit Bulgarian milk and *eiweiss milch* had produced in Germany, Dr. LaFetra told him to obtain the culture, have the milk prepared and start feeding it to these little patients at once. I might remark here that *eiweiss milch* was not recommended for young infants, but that infants of any age could take the Bulgarian cultured milk. At any rate, within 24 hours after this conversation, the Bulgarian milk was ready and was being given to the infants with the result that within a few days time the mortality rate dropped in a most spectacular manner.

This experience occurred in very hot weather, even for New York. When I returned home, which was only a few days later, I brought with me a culture of the Bulgarian

milk and began preparing the cultured milk in my own home and dispensing it to the sick-est children with diarrhea. We had on hand many cases of infectious diarrhea and the results here were like those in New York, of a most spectacular nature. I believe that Columbia was the first place in the South to use Bulgarian milk in intestinal disease. After it was used in Columbia, which was done promptly upon my return from New York, the news spread rapidly of the spectacular results from this treatment. Some of the doctors in Columbia were inclined to ridicule the reports emanating from this treatment. However, it was not long before the whole community realized its value and the use of Bulgarian milk soon became statewide. Previous to this time I had been using buttermilk with fair results, but not with the spectacular results experienced with Bulgarian milk.

In 1913 the Columbia Children's Clinic was organized and I was made Chief of Staff and for many years hundreds of infants and children from Columbia and the surrounding territory were treated from this clinic.

It was in 1920 that I became deeply interested in the study of vitamins. In my studies of the problems of nutrition, I observed that what was known of the vitamins was both scanty and disconnected, and I set about collecting all the information available in the United States and abroad, on the subject of vitamins, their names, sources and uses. I became deeply interested in the work being done by Sir Frederick Hopkins, McCollum and others in the study of vitamins and all of this study resulted in my constructing the vitamin chart, enumerating the various vitamins then known, their best sources and their functions. This chart was exhibited in the 1928 Scientific Section of the American Medical Association meeting in Minneapolis, Minn. and was reviewed with profound interest by quite a number of men, most of whom were authors of medical books. This was the first vitamin chart ever exhibited anywhere and the first correlated in the world, and placed in convenience for reference. It was reprinted in many different languages and my permission was sought by quite a number of authors of text books on infants and children to publish

it in their books. This permission was freely granted. The requests for the vitamin chart became such a nuisance to me that I turned it over to the Food Research Laboratory in Charleston.

In the late 1919 or 1920, I do not recall which year, Dr. John L. Morse who was then Dean of Pediatrics at Harvard, following Dr. Rotch's death, sent me a batch of case reports which had been sent to him by Dr. Patrick, an assistant of Dr. Bilderbach of Portland, Oregon, marked "cases for diagnosis", asking if these were not cases of some unusual form of pellagra. After reading them carefully I concluded that they were definitely not cases of pellagra, and in this opinion, my opinion was confirmed by Dr. Babcock who was an excellent authority on the subject of pellagra. I then took down a volume of Valley's System of Medicine, published in French and under the heading immediately following that of pellagra was "acrodynia". As best I could with the help of a French-English dictionary, I translated the article and concluded that here was the disease that meets the description of the cases sent by Dr. Morse. I wrote under Dr. Morse's brief note to me "these are cases of acrodynia, which is the English word for the French word acrodeni." Shortly I received the same note from him with the comment: "What in the hell is acrodynia?" and again under this inquiry I wrote "you will find an excellent article with description of the disease in Valley's System of Medicine which you can find in the Medical Library in Boston." I prepared and read a paper at the next meeting of the American Medical Association which was held in New Orleans. At that meeting Professor Morse and several members of his staff were present. After hearing my address Dr. Morse commented to me, "I did not need to refer to the Boston Medical Library to know all about acrodynia. You have stated it and stated it well." This article was published by the American Medical Association and it would appear that it was read by physicians in various countries in Europe. I was told that it was the first paper that was ever written in the United States on the subject. Several years later I was in London and visited Great Ormond Street Hospital. The receptionist introduced me to a

physician, whose name I do not recall and who, I think, did not catch my name. I told him that I had no doubt but that they had some interesting cases there and if so, I would like to see them. He said, "Yes, we have a ward full and I will be glad to show them to you." We proceeded to the next story of the hospital and in this big ward were many cases of what was manifestly acrodynia. They had all of the usual manifestations of established cases. I turned to him and said, "These are cases of acrodynia. Had you suspected it?" He said, "Yes, we have." I said, "What do you know about acrodynia?" He said, "All we know about acrodynia is what a man in America said about it." I said, "What is his name?" He said, "Weston." I told him that I was that man. He looked greatly astonished and was most apologetic for not having caught my name.

I taught pediatrics at the Columbia Hospital for a number of years. This curriculum of the nursing training school was established with me as the first teacher.

I was elected lecturer on pediatrics at the Southern Pediatric Seminar at Saluda, N. C. at its inception and was on the teaching staff for a great number of years.

Columbia had grown to such an extent that the ladies who owned and managed the Columbia Hospital gave up its management and turned it over to the Columbia Medical Society. During World War I, I had been assigned to the School for Chiefs of Service, which prepared its graduates for positions as chiefs of staff or chiefs of service, either medical or surgical and after my return from the Army, in which I had served as a Major in the Medical Corps, I was elected Chief of Staff and Chairman of the Board of Trustees of the Columbia Hospital.

I found the plant inadequate and the services below par. I presented these facts to the Board of Trustees and requested that they think carefully of building an adequate and decent nurses' home. I described the conditions in detail and pictured conditions as so deplorable that the Board was manifestly impressed and the motion was made to appropriate \$25,000 toward the building of a new home. I told them that this sum was totally inadequate and I wished \$125,000, which was

finally approved and voted. I reported other deficiencies which must be met. The question was naturally mentioned "where is the money to come from?" I said, "From a bond issue." I said the answer was to turn the hospital over to the County and vote a bond issue to meet essential needs. The chief lawyer on the Board said, "It would be illegal unless the law was changed." I said, "All right, let's change the law at the coming election and let us all get to work to have it passed."

In the meantime, Dr. LeGrand Guerry and I took to the streets begging money for the hospital and explaining its condition. We raised \$40,000, which at that time was a great help. A very earnest and successful campaign was conducted to carry the election. However, before this election was held the indebtedness had become so great and was so pressing that in certain instances I personally guaranteed that the debt of the hospital would be met in full. Some even threatened bankruptcy for the hospital. All of these anxieties were successfully dissolved and the hospital was put on its feet. The new nurses' home was built and instead of having one bathroom for 35 nurses, there was one bathroom for every 4 nurses, and other conveniences were met. The Board of Trustees, upon request from the Columbia Hospital Alumnae Association unanimously voted to name the new nurses' home "William Weston Hall" for me. Thus commenced an era for the Columbia Hospital for continued expansion and progress. I was Chief of Staff and Chairman of the Board of Trustees at the hospital for a number of years. When I resigned as Chairman of the Board and as Chief of Staff, I was presented a silver cigarette case and a silver match box by the Staff.

I have served as President of the Columbia Medical Society, President of the South Carolina Medical Association (in 1914); President of the Alumni Association of the Medical College of South Carolina, Chairman of the Section on Pediatrics of the Southern Medical Association, Chairman of the Section on Pediatrics of the American Medical Association and have held many other offices.

During my college days at the University of the South at Sewanee, Tenn., I became a member of the SAE fraternity. I am also a

member of the Alpha Omega Alpha (honorary medical fraternity).

I established the Southern Nutritional Association at Blowing Rock, N. C. in connection with Mayview Manor and drew its faculty from the chief pediatricians of various cities in the South. This Association met with eminent success and was discontinued only on account of the death of Mr. Alexander, the proprietor of Mayview Manor.

While on a visit to Minneapolis I became particularly interested in the problems of goiter prevention. I was called upon by Dr. J. F. McLendon, professor of physiological chemistry at the University of Minnesota, who informed me that he had analyzed vegetables from every state in the Union and found those from South Carolina higher than those of any other state in their iodine content, as the result of which, the vegetables furnished his children were all purchased from South Carolina and his were the only children on the campus who did not have enlarged thyroid glands. I was convinced from this report that this was a great opportunity for South Carolina, as all vegetables receive their mineral content from the soil in which they are grown. As a result of the studies of Dr. McLendon and those of other scientists of the goiter area of the United States, I made these facts known to Governor Richards. Thus came into being the South Carolina Food Research Commission. A laboratory was set up in Charleston in connection with the Medical College and Dr. McLendon's findings were fully sustained and many other facts of great importance were discovered.

So impressed with the studies that were made that Dr. Royal S. Copeland, member of the Senate from New York requested an interview with me, which was granted and he was so enthused by the revelation of our findings that he got up from his chair and walked back and forth in his office saying that this discovery should make South Carolina the richest state in the Union. I was besieged with requests from various sections of the goiter area of the United States to make addresses and accepted as many as I could and explained the physiology of iodine in the process of nutrition and its great importance and found great en-

thusiasm in each one of the places in which I spoke. On one occasion I recall a remark made by Dr. McLendon that unless the people of Minnesota received a sufficient supply of their vegetables from non-goiterous areas, the population could not extend beyond the third generation. On another occasion in which I spoke I used the expression in my opening remark, "Food is the determining factor in civilization," and I recounted in detail the results of iodine deficiency and I reminded the audience that iodine in its organic relationship as it occurs in fruits, vegetables and milk was the only source of effective iodine. The eminent Dr. Crile of Cleveland called attention in an address to the great number of mentally deficient children resulting from the food used deficient in organic iodine. Unfortunately the serious financial depression existing in the United States brought about the discontinuance in South Carolina of the Food Research Laboratory and the Natural Resources Commission, which had been organized to disseminate this knowledge. I found at that time that South Carolina's greatest asset was her soil which produced this wonderful element in sufficient amounts, because it is the element which accounts for the function and rate of function of all the glands and system of glands in the body by maintaining an absolutely normal thyroid gland.

During my term of service in the School for Chief Officers service, I was closely associated with my friend, Dr. Harold W. Mixsell who was at the time editor of *The Archives of Pediatrics*. Dr. Mixsell not only possessed a delightful personality, but he was highly educated and I considered him a scholar. At this time he and I were thrown together daily over a period of several months. We had frequent discussions on the various phases of nutrition and he persuaded me to write several articles for the *Archives of Pediatrics* and these articles were published in a series of issues. It became evident that they were widely read and appreciated and as a consequence I was called upon to make many addresses in various sections of the United States. I contributed articles to Abt's *Pediatrics* and to Brenneman's *Pediatrics* and have revised these articles from time to time. The article to which I attach

most importance was one on iodine deficiency in the diet of the large goiter areas of the United States. As a result of this article, at a meeting of the American Goiter Association held at Memphis, Tennessee, Dr. Charles Mayo discussed the surgical side of the problem and I presented the medical side.

On another occasion I addressed a large group of physicians from Illinois and Iowa on the subject of iodine deficiency and spoke of its sources. I hope I succeeded in blasting the theory that iodine was derived from the sea and in this connection, spoke of our findings in the South Carolina Food Research Laboratory that the tremendous amount of iodine in the soil of South Carolina was derived from the disintegrating igneous granite of the southern side of the Blue Ridge Mountains. I emphasized the point that the deeper down the soil that was examined, the greater was the amount of iodine. I also emphasized the point that oysters gathered from the sea coast along the long rivers were higher in iodine than those from the short rivers, and that the oysters did not derive their food from the ocean but from the land.

In concluding my remarks at this meeting I presented charts showing that the water and soil were very deficient in iodine in the goiter areas and that foods served in cans were to a great extent produced in the goiter areas; and on the contrary, foods of the same appearance and under the same names produced in South Carolina soils contained an ample amount of iodine to provide for the requirements of normal nutrition. The eminent Dr. Crile of Cleveland, called attention to the fact that the many weak-minded children found in the goiterous areas around Cleveland were suffering from an iodine deficiency. A distinguished pediatrics professor of a large Western University, and a professor of obstetrics called attention to the fact that many cases of failure of conception or miscarriage were attributable to iodine deficiency in the foods in the locality. Since South Carolina has such an abundance of iodine in its soil and consequently in the products grown in this soil, South Carolina's greatest economic asset is her agricultural products.

Over a considerable period of time I taught nutrition to classes of nurses at the Columbia

Hospital, especially in regard to the various formulas for the preparation of milk for infants and children. I also delivered a course of lectures to the Home Economic classes at Columbia College and to a group at the University of South Carolina.

I was a member of the organizing group of the American Academy of Pediatrics and was the delegate of the Pediatric Section of the A.M.A. to the House of Delegates for a great many years, and when the Pediatric Section of the Southern Medical Association was established I was its first Chairman.

While a member of the House of Delegates of the A.M.A. after having served in this capacity for several years, I was informed by the telephone company that I was to hold myself available at a certain evening hour for a hookup with a number of cities where there would be a spokesman in each one. This hookup was with physicians from the West, North and East, in which each one requested that I become a candidate for President-elect of the American Medical Association, and promised their delegation to my candidacy, and most of them said that they did not anticipate that there would be any other name offered. I greatly appreciated this compliment, but as it was, the cost for holding such an office was about \$100,000.00 and a subsequent short life of invalidism. Consequently, to each one I replied that I was not financially able nor did I wish to die as my predecessors had, so shortly after their term of office had expired.

In view of the fact that the members of the medical profession in Columbia were in rather critical groups, in which unkind language was too generously applied, I suggested a plan of reorganization, and in perfecting this plan I was ably assisted by Drs. Thomas Pitts, David Adcock and Barnwell Heyward. It was founded upon the avowed purpose of the membership speaking only kindly to each other and good will to each other. After the preliminary work was done, a largely attended meeting was held in which the plan was outlined. The plan was overwhelmingly approved by the members of the society and has proved a wonderful success and produced a united profession. I promised that we would have speakers of outstanding reputation to address

each meeting. I was made chairman of the program committee and held this office for a number of years. So pleased were the members of the Society that I had been the instigator of the increased interest manifested by the members, that I was later honored by the Society with a testimonial dinner at which time I was presented a plaque and a silver tray. It may be worth mentioning that in the reorganization of the Columbia Medical Society, I was also chairman of the program committee and over a period of years it became our custom to invite the President-elect of the American Medical Association to address the meeting. I think more than anything else that this accounted for the large attendance from this and from surrounding states, at our local meetings.

I have accepted invitations by the President of the United States and attended several

White House Conference meetings. These conferences have proved of value, especially in the field of nutrition in children and in the treatment of various diseases of childhood.

I have been honored by my patients in having my portrait painted and presented to the Columbia Hospital where it hangs in the lobby.

I have also been honored by the physicians of the State of South Carolina, who had another portrait painted of me and presented to the Medical College of South Carolina in Charleston.

I have had the following honorary degrees conferred upon me: Doctor of Public Health, by the Medical College of South Carolina; Doctor of Science, by the University of the South, Sewanee, Tenn.; and Doctor of Laws, by the University of South Carolina.

*Plasma levels of epinephrine and norepinephrine—
anesthetic significance.* William Hamelberg, M. D.,
James Sprouse, M. D., John E. Mahaffey, M. D. and
James A. Richardson, Ph. D., (Charleston) *J.A.M.A.*
172:1596—Apr. 9, 1960.

The physiological role of the adrenal medulla during surgical anesthesia is yet to be fully explained. Animal experiments tend to indicate that pentothal and fluothane have very little excitatory effect on the adrenal medulla whereas ether and cyclopropane

produce an increase in the plasma levels of the catechol amines.

Using the commonly employed techniques of producing surgical anesthesia in the human, the plasma levels of norepinephrine and epinephrine were measured both during light and deep surgical anesthesia.

The results of the study are an attempt made to correlate the clinical course of the patient and the plasma levels of the catechol amine.

EIGHT STEPS TO BETTER OLD AGE

E. VINCENT ASKEY, M. D.

President-Elect, American Medical Association

Delivered before South Carolina Medical Association President's Banquet, Myrtle Beach, South Carolina, Thursday, May 19, 1960.

I am not going to mince words this evening, since what I have to say concerns every one of you—doctors, wives and guests. You all know that the subject of health care for the aged has been lifted from the realm of medical and social interest and thrown into the arena of national politics.

Despite the injection of brutal party politics into the issue, we have managed to keep our heads above water. The proponents of national compulsory health insurance thus far have not been able to snow us under in their blizzard of emotional exploiting, politicking, and blatant distortions of the truth.

Just in recent months we have seen the full measure of our opponents' tactics. They have used every trick to befuddle and befog the American people, and in some cases, they have succeeded. They have applied enormous pressures on Congress to pass *some* sort of legislation—*any* legislation—that will provide some health care for the elderly under Social Security.

We have opposed the Forand bill and similar legislation, because we believe such bills either would be harmful to the health of our nation or would not do any tangible good.

Any objective, unemotional, non-political study will show that the majority of America's elderly enjoy reasonably healthy, happy lives, and are capable of continuing so.

Of the more than 15 million Americans over age 65, only 15 per cent are on old age assistance. An undetermined number, although able to finance other costs, find it difficult to withstand the additional costs of illness. It is for these people that something should be done.

Neither the Forand-type legislation nor the Administration's proposal will meet the problems of this group.

Of course, all of you have heard the hoary old battle cry of the "world-changers" that the A. M. A. *always* opposes, but *never* proposes.

I don't need to run down a list of A. M. A. actions and recommendations just during the last two years to show you how overwhelmingly our positive, constructive actions outnumber the negative.

Therefore, we make no apology for opposing Forand-type legislation. However, unlike the typical reactionary organization that we are supposed to be, we have developed an eight-point program for the health care of the aged. Here it is:

(1) *The Needy Aged*. These aged now receive health care through old age assistance programs. The need here is for better organized medical care programs, including improved preventive medical care;

(2) *The Near-Needy*. This is the group, whose size is indeterminate, who can meet ordinary costs of living but cannot pay for health care costs. The A. M. A. supports a state-administered program of federal grants-in-aid to the states for the liberalization of existing old age assistance programs so that the near-needy could be given health care without having to meet the present rigid requirements for indigency. A liberalized definition as *determined locally* would permit an expanded program and encompass the near-needy group;

(3) *Facilities*. Better nursing home facilities for the long-term care of the aged person especially those over the age of 75, is the most urgent health care need before the nation today. The average age of nursing home patients is 80, and their average duration of stay is 2 years. It is here that major improvement can be brought about. A. M. A. supports federal programs for the provision of grants through the Hill-Burton mechanism to provide for new nursing home additions to existing hospitals. For proprietary nursing homes the A. M. A. supported the recently enacted amendment to the Federal Housing Act providing for government guaranteed mortgage

loans to proprietary nursing homes. A. M. A. is also cooperating with the American Nursing Home Association and the American Hospital Association in an effort to bring about a rapid improvement in medical care provided in nursing homes;

(4) *Voluntary Health Insurance.* Health insurance and prepayment policies tailored to meet the needs of the aged for long-term nursing home care, must be developed as rapidly as possible. Health insurers and the Blue Cross and Blue Shield plans across the nation are already experimenting in this new area of coverage;

(5) *Home Nursing Care.* Care of the aged patient at home is psychologically, medically, and financially desirable. Many programs to promote home nursing care are being developed. Homemaker's services also provide opportunities for children caring for aged mothers or fathers to continue gainful occupation. They need to be expanded;

(6) *Attitude Toward Aged.* A basic change in attitude toward the aged person must be brought about. The person who reaches 65 has not suddenly become non-productive, and senescent. On the contrary, most persons over 65 are reasonably well and able to work. Increased productivity by eliminating compul-

sory retirement and permitting voluntary change of work is an essential part of the answer to the present problem;

(7) *Health Education.* Many older persons are unaware of the need for continuing healthful nutrition and other practices that contribute to good health. Above all the "will to live" is essential to continuing health. Preventive medical measures instituted long before the age of 65 also can contribute materially to the promotion of good health after age 65;

(8) *The Purchasing Power of the Dollar.* One of the principle economic problems of the aged person in the last twenty years has been the constant and continuing erosion of the purchasing power of his pension benefits. Any government program to help the aged must be anti-inflationary and maintain the purchasing power of fixed pension and annuity benefits.

Sensible, economical health care programs for the aged that preserve freedom at the same time that they promote security must necessarily be limited to support for the needy aged and leave to voluntary, competitive, private enterprise those activities needed to improve the health care of the rest.

MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

Enigmatic T waves

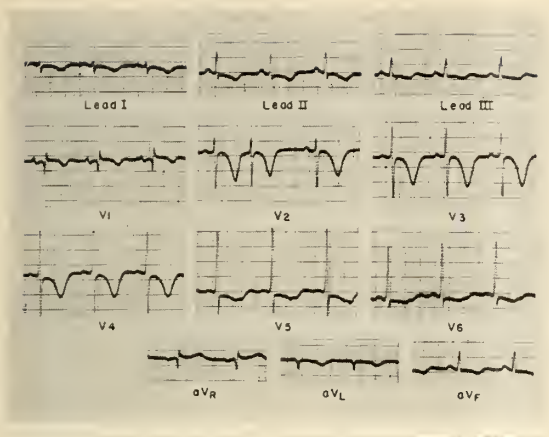
DALE GROOM, M. D.
Department of Medicine

Case Record—One of the perpetually puzzling aspects of electrocardiography is that of bizarre T waves such as illustrated in this tracing made two days postoperatively on a 36 year old lady who had undergone her second valvulotomy in five years for rheumatic mitral stenosis. Prior to this operation she had run the gamut of atrial arrhythmias from ectopic beats to paroxysmal tachycardia to atrial flutter and

fibrillation, all within an interval of three months. Quinidine was ineffective in controlling the arrhythmias. As the pressure in the left atrium dropped with manual dilatation of the mitral valve her rhythm reverted spontaneously to a regular sinus one and remained so throughout her postoperative course.

The patient had neither clinical nor laboratory indications of infarction or rheumatic fever when this ECG was recorded. Ones made preoperatively and several weeks postoperatively showed T waves which were unremarkable save for the ordinary changes of digitalis effect.

Electrocardiogram—The rhythm is regular except for an occasional supraventricular ectopic beat (V_2) and A-V conduction is normal. In some leads the P waves



appear a bit broad and notched, consistent with her left atrial enlargement. Axis of the QRS is directed downward and slightly to the right.

A conspicuous feature is the huge inverted T waves, of almost 10 mm. amplitude in V_3 , which appear to end about 0.44 sec. after onset of the QRS (though, curiously, the one of the ectopic beat in V_2 is much shorter). Their configuration in leads III and aVF suggests that they may be combinations of T and U waves, the T ending at about 0.36, followed by the termination of the after potential. T waves in the left precordial leads V_5 and V_6 are typical of digitalis effect.

Discussion—Gross abnormalities of T waves without evident cause are occasionally encountered in the day-to-day interpretation of tracings and constitute one of the unsolved mysteries of electrophysiology. Of all complexes of the ECG, the T wave is probably the most sensitive indicator of myocardial disease but at the same time the most misleading. So many conditions other than myocardial pathology (e.g., electrolyte disorders, digitalis and numerous other drugs, hyperventilation, emotional stress, the eating of a full meal or drinking ice water, often smoking or changes in posture or deep inspiration, occasionally reflex stimulation from the gastrointestinal tract as well as, of course, alterations in circulatory dynamics or in the cardiac rhythm or conduction) can profoundly alter the T waves so that deviations from contours regarded as "normal" must be viewed critically and in the light of the clinical findings.

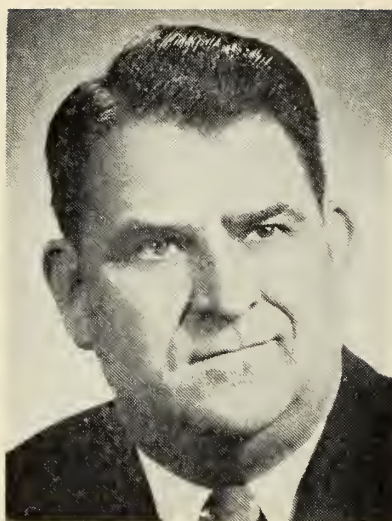
Expressions such as "ischemic T waves" are more descriptive than accurate. Probably the most common error in interpretation of electrocardiograms is the *over-reading* of minor T wave variations in terms of coronary or myocardial disease. The fallacy of too rigid application of dogmatic rules of interpretation is nowhere more evident than in patients suffering only from a diagnosis. Furthermore, marked variations in T waves and even in S-T segments are constant features of the electrocardiograms of some normal subjects.

Deep, wide inverted T waves such as these have been described as a distinctive pattern in patients with cerebral vascular accidents.¹ The mechanism of their origin is unknown. One hypothesis, that they may be caused by "sympathetic storms"² is not supported by any associated change in the heart rate or P-R interval, or by other consistent indication of disturbance in the autonomic innervation of the heart. Myocardial infarction is commonly followed by T wave inversions which may attain this amplitude, but there is no QRS evidence of infarction here. Extremely large peaked T waves are seen in hyperkalemia, characteristically upright in the precordial leads. The opposite — a low level of potassium (intracellular) — can give rise to U waves of huge proportions³ which are also usually upright but may be inverted and often merge with and seemingly prolong the T waves. Since U waves are well demarcated in some leads, the latter explanation, a transient depletion of intracellular potassium immediately following surgery, may be the most plausible in this case. But it is only conjecture.

There are many such enigmas of electrocardiography which lie between the known "classical patterns" of abnormality and are not yet reducible to physiologic or pathologic terms. They serve to remind us of present-day limitations of the art.

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President's Page

OUR MEDICAL COLLEGE

Over two-thirds of the members of the South Carolina Medical Association are graduates of the Medical College of South Carolina. Included in the remaining third are many others who also affectionately look on it as "our Medical College".

Our Medical College has had a long and honorable history. It has educated hundreds of native sons in the art and science of medicine, most of whom have remained to care for the people of South Carolina.

From its inception our Medical College has been a cooperative movement. Without the help of practicing physicians in Charleston, who served as its faculty, along with their regular practice of medicine, it could never have started, nor continued to survive. Throughout many years of its existence it was able to offer few fulltime professorships, and these mostly in the basic science subjects. The clinical teaching of both medicine and surgery was done practically entirely by practicing physicians.

The Roper Hospital and our Medical College are inseparable to many of us who now practice in South Carolina. For many years the Roper Hospital was the sole source of "teaching patients" for our Medical Students. It is not possible to think of these two institutions, which have meant so much to each other in the past, except as a continuing partnership into the future, with mutual benefits, and for each a definite share and responsibility in the education of South Carolina physicians.

Its Alumni Association has taken a great interest. Since early time, groups of its graduates have been generous with time and money, and have themselves inspired endowments. This is evidenced by donation of funds for the Alumni Memorial Clinic, and the gift of Baruch Auditorium, prior to 1944.

About this time, our Medical College found itself face to face with the problem of expanding and moving forward, or losing its accreditation and closing its doors. A mighty effort, bringing together our Medical College, its Board of Trustees, its Alumni, the State Medical Association, the Governor of the State, and the Legislature, resulted in a spirit of widespread cooperation throughout South Carolina, which has not stopped even with the completion of our multi-million dollar center. However, at times it appears to have slowed down.

Today we have an institution second to none for the education of our young people as physicians. Our Medical College now graduates twice as many as it did twenty years ago. However, this is only the foundation—our Medical College must continue to build and go forward. It cannot be allowed to stagnate. To do so would be to condemn it to a slow but certain and agonizing death.

We are entering a new era. Dr. Kenneth M. Lynch, in whose vision our Medical Center was conceived and under whose leadership and perseverance it was pushed to its present stage of completion, has stepped out as active President of our institution. As Chancellor, he will enjoy the emoluments of a well earned and honorable retirement. Meanwhile, continued cooperation between all segments of the Medical Profession and our Medical College is more urgent than ever before.

We can help in many ways: By seeking to influence top grade students to study medicine—To actively interest ourselves in Alumni activities—To so conduct our practice of medicine that the merit of continued support for our Alma Mater will be self-evident to our neighbors and the State Legislature. And, most important, I call on each of you to become even more conscious of the heritage left by the men of medicine, who during more than 135 years have given of their best for the upbuilding of our Medical College. And to pledge your cooperation in every way to the New Administration in helping to carry higher and further this lustrous record of all that is worthy and good in medical education.

Joseph P. Cain, Jr., M. D.

Editorials

KENNETH M. LYNCH, M. D. Sc., LL. D

The retirement of Doctor Lynch from the Presidency of the Medical College on June 30 brought to an end an era in medical education in South Carolina. This era had its beginning about the time of his coming. It has been characterized by a major trend of continual improvement. However, there have been interjected several serious interruptions to the major trend.

Shortly after Dr. Lynch had finished his graduate training in pathology in Philadelphia in 1915, he was invited to assume charge of the Department of Pathology in our school. He came down on an inspection trip and he did not like what he found. He reported to his chief that our little private, unaccredited medical college, even with its long and interesting history had nothing for him. His Chief thought otherwise. He saw in our situation a challenge to his young, capable, ambitious assistant. He advised the young pathologist to go to Charleston and to help in developing the Medical College of South Carolina. Dr. Lynch accepted the advice, and so became the first full time salaried professor of our school.

Dr. Robert Wilson, the greatly beloved dean, recognized Dr. Lynch's executive ability and he began grooming him to become his successor.

Two years after Dr. Lynch's coming, the college became State owned and administered. This implied financial support by a general assembly wholly unfamiliar with the financial needs of a medical school. Dr. Lynch assisted Dr. Wilson in his efforts to secure adequate financial support. This was fine training for the man who was to secure continuing financial backing and support for constantly enlarging demands by the college.

The school became conditionally accredited. Dr. Wilson asked to be relieved as dean, but World War I was on us. Under pressure, he agreed to continue for the duration.

After the end of the war and when condi-

tions had stabilized, Dr. Wilson resigned and Dr. Lynch was elected dean.

The new dean had never lost sight of the objectives, stated by his chief, when he left Philadelphia to come to Charleston. Along with those objectives, he had now become steeped in Charleston's history and traditions, and in the history of the Medical College. He thoroughly understood its problems and its opportunities. He already had a clear vision of the medical center, which we now have, of a faculty of well trained full time younger men to work with the local clinical men who had made the college possible throughout its long history.

What we came to call an expansion program became first a dream, then a topic of conversation, and then an objective and finally an undertaking. There has been no let-up in the undertaking. A few weeks before he retired, President Lynch announced a new building program to cost about two million dollars.

Dr. Lynch was instrumental in having the name of the college changed back to its original name, the Medical College of South Carolina. Then his title was changed to president, the better title for the executive head of a college, and distinctive from deans of Departments which were soon to come.

He became friend and confidential advisor to many important political leaders, while still holding the confidence and admiration of a majority of the medical practitioners in the State. And so the program of expansion, of growth, of improvement continues.

Now has come the time for his obligatory retirement under the State Retirement System. The Board, with political approval, has made provisions for his retirement years. He will continue his connection as a staff member of the Medical College hospital, and he plans to continue his consultation practice in pathology.

Dr. Lynch has been given the title of Chancellor by the Board. That title was selected

rather than that of President Emeritus, which would emphasize retirement because of age. His retirement was required by regulation of the State Retirement System.

The meaning of the title Chancellor is rather indeterminate. It is a title of respect, of dignity, and importance. More than that, its meaning is subject to individual definition. With us, it does not mean or imply executive head. Our President is still the chief administrative officer of the school. However, the Board has specified that our Chancellor shall be advisor to the Board and to the President on specific problems, when such advice is asked. Additionally, he has been asked to continue to act as medical college representative on the joint committee of the Roper Board of Commissioners and the County Council, along with the Medical College, which committee is seeking a mutually satisfactory solution to the problem of hospital care for Charleston's indigent sick. Two other specific duties assigned to him will be to manage faculty contributions to A. M. E. F. and to continue to assist in securing research grants for the several departments of the school.

Because of his willingness to serve in these capacities, Dr. Lynch's long experience and vast detailed knowledge will be available to assist in inaugurating a new era, and will help provide for a gradual transition from the old into the new.

Dr. Lynch has said that he plans to write a history of the Medical College of South Carolina. No one is better fitted for that important and needful task. Such a book will be awaited with impatient anticipation.

And so adieu to President Lynch and welcome, Chancellor.

J.D.G.

VOLUNTARY AGENCIES

Forty years ago the Rockefeller Foundation provided funds which assisted in the establishment of the National Health Council as a clearing house and advisory body for national voluntary health agencies. Twenty years ago it made a grant to finance the study of voluntary health agencies which emphasized the need for increased cooperation and planning among these agencies. Much good has come

from these studies, and now the time seems more than ripe for a reassessment of the whole field of voluntary giving.

Like many of us, the Foundation is concerned with the multiplicity and complexity of unresolved issues which may "increasingly confuse the public, undermine public confidence and endanger the support of all private agencies." It is well known that there has been a tremendous increase in the number of agencies which solicit private contribution and claim a part of the nearly eight billion dollars which the public has been contributing recently to such efforts. The great increase in the number of these agencies has been somewhat confusing, and there has appeared to many people to be unfortunate overlapping and competition which result in the expenditure of a considerable portion of the collected funds for administrative expense. There are 100 voluntary health and welfare agencies that conduct national or regional campaigns, of which two-thirds have been established since 1940 and one-half since 1945. There is little wonder that in some fields there must be highly competitive activity and the criticism is sometimes advanced that some of the larger agencies have built up such enormous administrative structures that they feel compelled to expand their efforts to areas which were not included in the original program. The tremendous increase in the amount of federal funds contributed to health and welfare objectives has made the general situation even a little more complicated to the inquiring observer.

The Foundation now proposes a new study of the various aspects of the question of voluntary health and welfare agencies. It proposes to inquire into the questions of public appreciation of their activities, of the existence of criteria by which the public can judge the programs, of the effect on private agencies of governmental activities, of accounting methods, of research and professional education and a number of other facets of the broad question. The study is to be a rapid and preliminary one, and certainly as such or in a more expanded form it should produce immensely valuable information which will clarify the number of unsettled questions for

all of us who are interested and participate in the activities concerned.

THE SCIENTIFIC SESSION

In past years there has been occasion to bemoan the small attendance at the scientific sessions of the Association. It has been disappointing to see a sprinkling of people sitting before some well known physician who has perhaps come hundreds of miles and put himself to considerable inconvenience to address the members.

This year there was a much better show. On Wednesday afternoon the attendance was good. No count was made, but thinking to get some indication on Thursday of what the attendance was, we kept a rough count of the number of people in the hall for the various papers. Obviously the numbers do not represent the same people as there was much coming and going depending on the interest of various topics. The morning started off fairly well with 95 doctors in the hall and the number fluctuated all during the day from a low of 86 at the discussion on Perinatal Problems to a high of 128 at the discussion of the Burned Patient. Even the last panel could show a gathering of 107 members.

This is better but still not as good as it might be considering that there was a registration of over 500 physicians. What was responsible does not appear. Certainly the material provided on the program was excellent, and some extra effort was made this year to interest people in staying through the scientific session. Perhaps even the weather was helpful, as it was a bit too cool to tempt many members into their bathing suits. How to insure a really full audience for our guest speakers still remains a bit of a mystery.

CIVIL DEFENSE

At the last meeting at Myrtle Beach there was some discussion of the manner in which the Association was connected with the broad picture of civil defense, and certain suggestions were made for improvement of the present arrangement. Up to now the president

and the president-elect of the Association have been representatives of the Association ex-officio, and with the annual change of officers there has been no great continuity about the connection with the Civil Defense Commission. Council prepared a resolution recommending to the Commission a new arrangement whereby a medical director and deputy medical director who would be members and probably employees of the South Carolina Medical Association would be appointed in place of the ex-officio members previously in office. It is conceivable that duties of the director might be quite extensive and onerous, and it seems hardly a proper arrangement to expect one or two of our members to devote the large amount of time which potentially might be necessary for the positions. No definite action was taken as the arrangement would have to be approved by the Civil Defense Commission, and no steps were proposed for any immediate changes.

REPORT OF THE MEDICAL ADVISORY COMMITTEE TO THE CRIPPLED CHILDREN SOCIETY OF S. C.

The Medical Advisory Committee has been in close touch with the activities of the Society throughout the year, and has endeavored to give such assistance as it could toward the solution of several problems which arose. These problems were concerned partly with the difficulties encountered because of the unapproved activities of an organization which wished to raise funds for the cerebral palsied child. Because of the manner in which this rival campaign was conducted, and because of the total lack of any communication with the medical profession as a whole or with this committee, the Advisory Committee was strongly opposed to the activities which were carried on in several areas of the State, and which were very confusing to the public and indeed to many physicians. This rival organization has made no report of its plans or apparently shown any desire to have the approval and cooperation of the profession.

Several members of the Committee have attended meetings in Columbia. The usual annual luncheon for the Committee was held at the last meeting of the Association in Columbia and will be repeated this year at Myrtle Beach.

The Committee is of the feeling that the Society is conducting its affairs in an entirely desirable manner, and wishes to re-endorse its program and hopes to be able to do what it can to promote its success.

J. I. Waring, Chairman



DR. B. J. WORKMAN
OF WOODRUFF, S. C.
Vice President for 1960-1961

Dr. Workman is a graduate of Furman University and of the Medical College of South Carolina. He is a veteran of World War I, and a Fellow of the International College of Surgeons. A short time ago he was awarded a "Doctor of Humanities" Degree from Furman University. He is a member of the Hospital Advisory Council of the State Board of Health, a Trustee of Furman University, Past President of the Spartanburg County Medical Society and has served on the Spartanburg County Board of Education. He is also Assistant President of the Woodruff State Bank. With Dr. B. J. Workman, Jr. and Dr. John A. Workman he conducts the Woodruff Memorial Clinic at Woodruff.

MINUTES OF COUNCIL MEETING Myrtle Beach, S. C., May 17, 1960

The first meeting of Council in conjunction with the Annual Meeting of the Association was called to order by the Chairman, Dr. C. N. Wyatt at 9 a. m. All members of Council were present.

The minutes of the Special Meeting of October 7,

1959 were approved as published. The minutes of the Special Meeting of March 23, 1960 were read, corrected and approved.

The Chairman reported that a bill had been passed by the Legislature, House Bill #2572, allowing previously licensed naturopaths to obtain a license for the practice of osteopathy by payment of a fee and without examination or determination of qualifications. After considerable discussion, participated in by most members of Council, the following actions were taken:

1. Council expressed opposition unequivocally to such a bill becoming law, and the Secretary and Legal Counsel were directed to frame an expression of opposition and send it to the Governor immediately requesting that he veto the bill.

2. Mr. M. L. Meadors, Executive Secretary, was directed to consult the Attorney General of the State and find out if such a bill would be considered constitutional.

Dr. W. Atmar Smith, Chairman of a Special Committee appointed to study the matter of the establishment of a Benevolent Fund for the Association, appeared and presented the recommendations of his Committee. After some discussion, during which an amendment to change the maximum length of service on the Board of Directors of the Benevolent Fund from three terms to two terms was lost, Council approved the proposed plan and referred it to the House of Delegates with a recommendation for adoption.

The Treasurer, Dr. J. Howard Stokes, presented his report which showed a surplus of \$16,000 for the year 1959. This was accepted with the thanks of Council.

Mr. Meadors stated that the hotel management had suggested the inclusion of an additional charge for tips with the hotel bill and Council approved this change.

The Editor, Dr. J. I. Waring, gave his report which was received as information, with the thanks of Council.

The Executive Secretary, Mr. M. L. Meadors, then made his report; this was received as information, with a special commendation to Mr. Meadors for the preparation of a brief as amicus curiae, in the case of the radiologist's litigation in Spartanburg County. Mr. Meadors also was thanked by Council for his additional help in the establishment of the Insurance Program for the Association.

The Secretary then read his report which was received as information.

The President of the Association, Dr. William Weston, Jr., noted that the President was ex-officio Medical Director of Civilian Defense for the State, and the President-Elect was Deputy Director. It was felt that these offices should be more properly filled on the basis of long term service, appointed by Council, and a recommendation to this effect was authorized for presentation to the House of Delegates.

Dr. Frank Owens reported to Council that it was unlikely that any physician would be called in the

near future to serve by virtue of Selective Service. He then reported that the change in the registration law for physicians had been prepared with the help of Counsel and was to be presented to the House of Delegates for approval. Dr. Owens then presented the matter of the fee schedule in Workman's Compensation cases; Dr. J. P. Cain discussed this matter at length and it was recommended that the changes in the fee schedule proposed by the State Chamber of Commerce be referred back to the Committee on Industrial Fee Schedule for study, with power to act. A motion to this effect was passed.

Dr. J. I. Waring reported on his activities as the Director of the Public Relations Department of the Association, and of the T-V and Radio Programs which had been prepared under his direction during the past year. This was received as information, with the thanks of the Association's Council, and Dr. Waring was directed to extend to the various T-V and Radio Stations the thanks of the Association.

Dr. Waring then suggested that an information folder for new members of the Association be prepared, and he was authorized to continue efforts in this regard.

Dr. G. D. Johnson, President of the South Carolina Medical Care Plan, then presented his report to Council. Dr. Johnson noted that there were a large number of federal employees eligible for Blue Cross and Blue Shield coverage, and as President, he requested authorization to send a letter to such employees, along with the President of the S. C. Hospital Association recommending these plans. A motion to extend this authority to Dr. Johnson was adopted. Dr. Johnson then presented the list of nominees as directors of the S. C. Medical Care Plan, which was to be presented to the corporate meeting later in the day, as follows:

Dr. Izard Josey to succeed Dr. C. R. F. Baker
Mr. J. H. Epting to succeed himself.
Dr. J. H. Jamison to succeed himself.
Mr. Capers L. Peterson to succeed himself.
Dr. W. H. Prioleau to succeed himself.
Dr. R. Cathcart Smith to succeed himself.
Dr. J. P. Cain, ex-officio, to succeed Dr. William Weston, Jr.

The report of the Mediation Committee was read and received as information.

The report of the Special Committee in regard to Whitten Village, Dr. D. L. Smith, Chairman, was read and received as information.

Dr. Clay Evatt stated that there was no further report from the Insurance Committee.

The matter of the essay contest for high school students was presented and approved for next year.

Council then by unanimous vote recommended the nomination of Dr. J. Howard Stokes as Treasurer of the Association, to be presented to the House of Delegates.

The following nominees as members of the Media-

tion Committee were selected by Council for presentation to the House of Delegates.

First District—Dr. Henry C. Robertson, Jr. and Dr. Warren Smith.

Fourth District—Dr. Anthony White and Dr. Sam Moyle.

Seventh District—Dr. S. E. Miller and Dr. T. M. Davis.

The matter of nominations to a panel for selection as members of the Medical Advisory Board to the S. C. Industrial Commission was presented and the following nominations were made:

Pathologists

Dr. McK. P. Moore, Charleston
Dr. E. E. McKee, Charleston
Dr. Hunter May, Greenwood
Dr. D. J. Greiner, Florence
Dr. E. S. Cardwell, Columbia

Radiologists

Dr. S. W. Lippincott, Charleston
Dr. William A. Matthews, Rock Hill
Dr. Henry Plenge, Spartanburg
Dr. Ray Russell, Conway
Dr. J. Harvey Atwill, Jr., Orangeburg

Physicians

Dr. Ripon W. LaRoche, Camden
Dr. W. W. Edwards, Greenville
Dr. I. G. Linton, Charleston
Dr. C. Tucker Weston, Columbia
Dr. H. Leon Poole, Spartanburg.

The matter of the policy of Council in defraying expenses of a student representative to the Student AMA, for their meeting next year, was approved.

Council then expressed its approval of the Keogh Bill, passed by the House of Representatives and now before the U. S. Senate. The Secretary was directed to notify the Senators of this action.

There followed a discussion of the various Forand-type Legislative Bills in Congress, with extension of Social Security benefits, and Council directed the Secretary to write to all Congressmen and Senators expressing their approval for help to the indigent only through currently available channels, and not through extension of Social Security Benefits.

The Chairman noted that he had received from the Chairman of the Program Committee a suggestion for the payment of honoraria to out-of-state speakers at the Scientific Session. Council then directed that \$1000 be allocated for honoraria for out-of-state speakers at the next meeting.

Dr. A. L. Burnside reported that the Columbia Medical Society had adopted a resolution to the effect that the Legislative Representative of the South Carolina Medical Association should reside in the greater Columbia area. This was received as information.

Dr. William Weston, Jr. then gave his report as Delegate to the American Medical Association.

There was no further business and Council adjourned at 12:30 p. m.

MINUTES OF COUNCIL MEETING

Myrtle Beach, S. C., May 18, 1960

Council reconvened at 8:30 a. m. at the Ocean Forest Hotel on the morning of May 18, 1960. The Chairman of Council, Dr. C. N. Wyatt, called the meeting to order; Drs. Weston, Smith, Brewer, Scurry, Cain, Perry, Gressette, Burnside, Waring, Stokes, Crawford, Johnson, Evatt, Wilson and Mr. M. L. Meadors were present.

Dr. J. P. Cain reported on the telegram, letter, and resolution which had been forwarded to the Governor requesting his veto of House Bill #2572. There was a general discussion as to the best procedures to follow, but no further action was taken by Council.

There was no further business and the meeting adjourned at 9 a. m.

Respectfully submitted,
Robert Wilson, M. D.
Secretary

MINUTES OF COUNCIL MEETING

Myrtle Beach, S. C., May 19, 1960

The meeting of Council was called to order at the Ocean Forest Hotel at 8:30 a. m. by the retiring Chairman, Dr. C. N. Wyatt. Present were Drs. Gressette, Perry, Booker, Evatt, Scurry, Eaddy, Burnside, Brewer, Waring, Wilson and Cain.

After some discussion, it was felt inadvisable for Council to make nominations at this time for the offices of Medical Director of Civilian Defense, and Deputy Director, and Dr. William Weston was asked to continue in this capacity, with Dr. J. P. Cain as Deputy Director, until Council decides on permanent nominees for these positions.

Dr. J. I. Waring was reelected Editor of the *Journal of The South Carolina Medical Association*, and Mr. M. L. Meadors was reelected as Executive-Secretary of the Association.

It was decided by Council that the next Annual Meeting of the Association should be held in Charleston, either during the last week in April 1961, or the first week in May. The Executive Secretary and the President were authorized to make arrangements for the meeting on these dates.

The following were then elected as officers of Council for the next year. Dr. J. H. Gressette, Chairman, Dr. A. F. Burnside, Vice-Chairman, Dr. William L. Perry, Clerk.

Council then had the pleasure of an official visit from Mrs. Ramsbottom, retiring President of the Woman's Auxiliary, and Mrs. Smith, the incoming President. Both gave short talks regarding the affairs of the Woman's Auxiliary, which were received with great pleasure as information.

There was no further business and Council adjourned at 9 a. m.

Respectfully submitted,
Robert Wilson, M. D.
Secretary



"You can send him in now."

MINUTES OF COUNCIL MEETING

Columbia, S. C., March 23, 1960

A special meeting of Council was held in the Columbia Hotel on March 23, 1960. The meeting was presided over by the Chairman of Council, Dr. C. N. Wyatt. Members present were Drs. Burnside, Bozard, Scurry, Gressette, Weston, Brewer, Perry and Mr. M. L. Meadors. Also present was Dr. Frank Owens of Columbia, Chairman of the Committee on Legislation and Public Policy.

The Chairman stated that the purpose of the meeting was to make plans for the public hearing before the Senate Legislative Committee on the Osteopathic Bill recently introduced by Senator Dennis of Berkeley County, it being specified by Senator Dennis that he introduced the bill by request.

It was pointed out that the Osteopaths were asking for the privilege to use drugs and the use of the radiologists to read their films. It was the feeling of the reporter that it was simply a wedge to open the door for full freedom to practice medicine. It was pointed out that a Dr. Johnson in Summerville was the leader of the group sponsoring the bill.

The public hearing has been set for April 5, 1960. The State Hospital Association will have representatives to appear against the bill.

It was pointed out that the President of the Association, Dr. Weston was to be away on that date. Motion made by Dr. Burnside that a postponement be requested on the basis of the officials of the Association being unable to attend. Motion was seconded by Dr. Bozard and passed unanimously.

The next discussion was to make plans in case a postponement was not granted. It was suggested by Mr. Meadors that the doctors in the counties, whom

the Medical Affairs Committee Members represented, should contact the Committee Members.

It was then directed by Chairman Wyatt that the Executive Secretary write to the President and Secretary in each county, wherein a Medical Affairs Committee Member resided, asking them to contact the said member before the date of the hearing and request that they (the president and secretary) also attend the public hearing. The Chairman also directed the members of Council from the Districts involved to follow through and see that the President and Secretaries carried out their assignments. Dr. Burnside urged that efforts be made to have at least two doctors present from the county that had a Medical Affairs Committee Member. The total number desired being 20-25 doctors.

The next topic of discussion was the bill concerning Naturopathy, primarily Representative Mitchell of Oconee, who is a naturopath. Dr. Owens stated that there was sympathy apparently for Representative Mitchell and he proposed the following motion: "That Council go on record as opposing the bill as now prepared to allow C. A. Mitchell to be allowed to practice Naturopathy". At this time Dr. Evatt suggested that in place of the man's name the word "anyone" be substituted and this was accepted. Dr. Gressette offered a further change and it was finally accepted as follows: "that the Council continue the stand of the Medical Association as opposed to the Naturopathic bill as presented last year". This was voted on and passed unanimously. Dr. Owens reported on the chiroprapist bill and stated that his committee had no opposition to it.

Dr. Owens next reported on the Blood Labeling Bill and this was discussed. It was the opinion of his Committee that the Association offer a scientific opinion and take no part openly. Mr. Meadors informed Council that Senator Gressette had written him for expert information concerning the matter and he had communicated immediately with a noted hematologist from Tennessee, a Dr. Diggs, and thus supplied Senator Gressette's request. The crux of the information obtained was that there was no justification for labeling. He noted further that he received a note of appreciation from Senator Gressette saying that it was most helpful to him and his committee.

At this time we were joined by Mr. Starlin and other representatives from Blue Cross and Blue Shield. They informed the Council that the plans were being "used" by some, i. e., keeping patients in hospitals too long (apparently) with a diagnosis that ordinarily would not be expected to require that many hospital days. They stated that it was costing the plans a great deal of money. They pointed out that these occurrences were more prevalent in the 8th and 6th Districts. When this was pointed Dr. Gressette and Dr. Perry agreed that they would call a meeting at their own adjudication to meet in the near future and let the matter be carried to the Committee by representatives of the Blue plans.

Dr. Weston lead the discussion of the courses

offered in Civil Defense. It was suggested by Dr. Brewer that the Association appoint a committee to select and send a man to the school. No action was taken.

We were informed by Dr. Weston that Dr. Cantey of Columbia has informed Governor Hollings that he could not serve on the State Hospital Commission, Dr. LaBorde having been elected by the House of Delegates to this position.

President Weston then informed the Council that he had sent a telegram to Vice President Nixon and Secretary Flemming voicing our objections to the Forand Bill.

There being no further business the meeting was adjourned.

Respectfully submitted,
William L. Perry, M. D.
Acting Secretary

This letter has been widely circulated, but is reprinted for those who might have missed it.

**GREENWOOD COUNTY MEDICAL
SOCIETY**
Greenwood, South Carolina

April 22, 1960

Representative Aime J. Forand
House of Representatives
Washington, D. C.

Dear Congressman Forand:

The Greenwood County Medical Society objects to the principles expressed in the Forand Bill and similar bills. This Society is composed of thirty-five plain, ordinary physicians practicing medicine under the free enterprise system without the benefit of subsidies.

We agree that the 16 million people over 65 years of age constitute a health problem. We differ with you on the solution to the problem. Before being taxed further to carry out your plan we would appreciate information on several aspects of the problem from your viewpoint.

How many of the 16 million people over 65 years of age are unable to set aside from their income or by donations from their families 18.7¢ daily? Enclosed is a policy of the Blue Cross - Blue Shield Plan in South Carolina for people over 65 years of age. The cost is 18.7¢ daily. We prefer this plan to your bill. Forty-seven of the seventy-six Blue Cross - Blue Shield Plans in the country have similar policies available to people over 65 years of age.

The Blue Cross - Blue Shield Plan in South Carolina has an operating cost of ten percent. Ninety percent of the income received returns to the subscriber. If the tax money set aside to carry out your plan were kept in a separate fund and administered on a business-like basis, could you expect the federal government to administer your program at a cost of ten percent or less? Can you give examples of any tax supported government business now operating for as little as ten percent?

We believe the quality of care given by this Blue Cross - Blue Shield Plan is better and the money spent by the subscriber comes back to them in a greater proportion than would be possible than if the federal government attempted to carry out your program.

Taxpayers in all parts of this country are more aware every year of the fact that everything the government gives to the people, it must first take from the people. We know and you know that the federal government can not give us something for nothing. We ask you to show that the federal government's plan for medical care of the senior citizens can be given as economically as the South Carolina Blue Cross - Blue Shield Plan and at the same time maintain the quality of medical care expected and deserved by Americans.

How many of the 16 million people over 65 years of age have little or no income and no family to contribute to their welfare? These people now have medical and hospital care whenever needed of the finest type and for an unlimited time in South Carolina. The state and federal government already take from our tax money enough to pay the hospitals, the pharmacist, the social workers, the ambulance drivers and everyone else except the physicians. We are not objecting to this system for these people. We wonder how the passage of your bill could offer any more. Your bill would compensate some services of physicians which at present are freely given. We feel the additional income to physicians would neither compensate for the reduced quality of medical care which would result nor for the increase in tax which the people would pay.

Why would the quality of the medical care suffer? The existing facilities and personnel would be strained to the point of inefficiency by a sudden demand for study of all aches and pains. Physicians would resemble clerks in a store at a one-day-fire-sale.

Does your philosophy of service to people over 65 years of age include legal aid? Is service of a lawyer any less necessary when needed or the expense any easier to pay?

In October 1942 the Supreme Court handed down this dictum: "It is hardly lack of due process (of law) for the government to regulate that which it subsidizes". The regulation of medicine by the government is not what the patient nor the doctor wants in our opinion.

Even without the health insurance your bill promotes, the federal government spends 3.4 billion dollars a year for health. This is the conclusion reached by the U. S. Budget Bureau in the first real survey of federal spending for health as pointed out in U. S. News and World Report, April 11, 1960.

The founders of this republic meant to form a government that would allow each individual to enjoy personal rights and freedom so long as he did not abuse the rights of other individuals. Business was to be run by the people not by the government. Utopian plans for the government to regulate the lives of the

people — what they can plant, how they must sell, whom they can hire, the hours they work — are wrong morally and politically.

We believe that many Americans would still prefer to earn their own security. We can only hope that legislators will listen to the wishes of the taxpaying electorate more and discount the crying, wailing voices of labor union leaders and other cradle-to-the-grave lobbyists who feel as Harry Hopkins that "the people are too damned dumb to understand".

P. L. BATES, M. D.

for Greenwood County Medical Society

CORRESPONDENCE

May 17, 1960

Dr. William Weston, Jr., President
South Carolina Medical Association

Dear Sir:

I would like to thank you and the South Carolina Medical Society for making possible my trip to the tenth annual Student American Medical Association Convention in Los Angeles, California on May 4-8, 1960. It was an experience that I will never forget, and I was greatly honored in being able to represent the Medical Students at the Medical College of South Carolina.

The House of Delegates met on May 5 and May 8, and representatives from 50 medical schools in the United States and Puerto Rico were present. At the first meeting, numerous resolutions were introduced, and after appropriate committee study, these were discussed and voted upon at the second meeting. Some of the resolutions that were adopted included:

1) A plan to study a program to institute "Future Doctor's Clubs" in high schools throughout the country.

2) A recommendation to the American Association of Medical Colleges that it "intensify its program to interest Superior Students in a career in Medicine."

3) A recommendation that "legislation pertaining to medical care of the aged would be premature, and that such legislation should be postponed until a comprehensive study of the problem is completed."

Also presented to and accepted by the House of Delegates were the annual reports of the SAMA standing committee on Medical Education, Graduate Training, and Current Trends. Elected as national SAMA President for 1960-61 was Bill Waddell, a Sophomore Medical Student at Duke University Medical School.

Highlights of the scientific sessions included a talk by Lt. Col. Burt Rowen, MC, USAF, Chief of Human Factors Research, Edwards AFB on "Biomedical Frontiers of Space", a talk by Dr. Edward Bloomquist on "Why do Doctors take Narcotics?", a panel discussion on "The Pro's and Con's of Forand Type Legislation", a talk by Dr. Charles Wahly, psychiatrist, at UCLA, on "The Fear of Death and Its Manage-



An important event at the Medical College occurred on June 30, 1960. The retirement of Dr. Kenneth M. Lynch, president of the Medical College since 1949 and before that long-time vice dean and dean, left room for the succession of Dr. John T. Cuttino, dean of the School of Medicine and executive vice-president of the College. Dr. Cuttino will serve as acting-president.

Dr. Lynch's achievements in the scientific field are

well known, and his part in the development of the Medical College has been unique. He continues as Chancellor and will serve in several other important capacities. Dr. Cuttino, a Medical College alumnus and like Dr. Lynch, a pathologist, has had much scientific and administrative experience and comes well prepared to his position of greater responsibility and opportunity.

ment", and a panel discussion moderated by Raymond Burr (TV's "Perry Mason") on "Murder, the most overlooked Cause of Death." On this panel also were Erle Stanley Gardner, and Dr. Frederick Newbarr, Chief Autopsy Surgeon, Los Angeles Coroner's Office.

We also enjoyed the pleasure of three luncheons for the delegates and alternate delegates. One luncheon by the American Academy of General Practice featured a talk by Dr. John G. Walsh, the Academy's President. Another luncheon was sponsored by the AMA and we were privileged to hear a talk by Dr. Louis E. Orr, President of the AMA. The third luncheon was given to us by Wyeth Laboratories, at which a talk was given by Dr. Edward R. Pinckney, Editor of *The New Physician*.

Another interesting part of the convention was the twenty-five scientific exhibits prepared by medical students, interns, and residents. There were also 38 technical exhibits presented by the various pharmaceutical, book, and allied companies. Over 100 photographs which were entered in the Photographic Salon were also exhibited.

Again, I would like to express my appreciation to you for making this trip possible. I feel that it has

better qualified me to serve my fellow students, to be a better physician in the years to come, and to better understand and appreciate the many varied aspects of organized medicine.

Sincerely yours,
J. William Allgood, President,
SAMA, Medical College of S. C.
Charleston, South Carolina

SWANSEA NEEDS A DOCTOR

A doctor is needed to serve the 10,000 people who live in the sandhill region around this lower Lexington County town.

Swansea has a part time doctor who visits the community every week-day night except Wednesday. Dr. Leo Kirvin, a member of the staff at Columbia Hospital has office hours in the community from 5 o'clock until 8 or 9 o'clock, "or until the work is done".

But the nearest full-time doctor is in North, and there is a wide area of Orangeburg, Lexington, and Calhoun County which needs the services of a physician in the central town of Swansea.



*Important People at the Annual Banquet, Myrtle Beach, 1960.
Dr. William Weston, Jr., president; Honorable James F. Byrnes; Dr. E. Vincent Askey, president-elect of the A.M.A.*



BLUE CROSS . . . BLUE SHIELD



COLORADO MEDICAL PLAN POINTS THE WAY

(Abbreviated from an Article by Bob Tonsing, Staff Writer, *Denver Post*, Denver, Colorado.)

A national medical care program for the aged? Colorado's plan for pensioners might be just what the doctor ordered.

Now in its third year, the plan has been widely praised as a gem of efficiency and effectiveness in a field often characterized by administrative waste and tragic futility.

The Colorado Welfare Department has a fund of \$10 million earmarked for annual expenditure in the medical program for pensioners.

About \$3 million of this is handled by the Welfare Department for pensioners' care in nursing homes, drugs for patients in nursing homes and several miscellaneous programs amounting to less than \$100,000 each.

The rest — about \$6.5 million — is spent for a medical care program with benefits similar to those of good medical insurance plans of the kind many younger people are enrolled in.

As a matter of fact the program is even administered by the people who run the Blue Cross-Blue Shield plans in Colorado.

But it is not insurance. It is a sort of cost-plus under

which Blue Cross-Blue Shield picks up the medical bills as they come in. The state, in turn, reimburse Blue Cross-Blue Shield and gives it a little something extra for its trouble.

The extra amounts only to actual expenses incurred in dealing with the pensioners, the doctors and the hospitals, since Blue Cross-Blue Shield are non-profit organizations.

In 1959, these administration costs amounted to 2 per cent of the entire bill. If the state were to handle the paper work of the program itself, some experts say these costs might run from 10 to 15 per cent.

Here's how Colorado's unique medical care program works:

All 52,000 Colorado pensioners are issued identification cards. Any pensioner is eligible whether he's getting the maximum \$106 cash payment a month or a mere \$1 a month.

The card tells hospital and doctors that the bearer is entitled to benefits comparable to Blue Cross' Comprehensive Plan and Blue Shield's Standard A Plan.

Translated, this means a pensioner gets fully-paid care in a semi-private room (not a ward), with all hospital, surgical and medical costs covered.

He can stay 30 days normally, but if the trouble warrants the Welfare Department can authorize ad-

ditional periods of full hospital coverage.

The card also entitles a pensioner to doctors' visits outside the hospital. He may summon a doctor to his home, or go to the doctor's office, two times every three months; the state, through Blue Cross-Blue Shield, will pick up the tab.

In addition, the Blue Cross-Blue Shield office handles administration of doctors' calls to pensioners put up in nursing homes.

The state will pay for as many as six routine doctors' calls at nursing homes every three months, or 12 calls during that period if the patient's health demands it.

The program is liberal. It treats the pensioner like an insurance beneficiary, not a ward of the state.

Malingering has not been a problem. On the contrary, Colorado's senior citizens have been staying in the hospital only an average of 11.72 days per admission. This is two days less than the national average for people 65 and over.

What about the doctor's office privileges? Do the pensioners use up their excess visits for socializing?

Blue Cross says they don't. Theoretically Colorado's 52,000 pensioners could use up a total of more than 400,000 visits a year. They've been seeing the doctor only about 90,000 times a year, the records show.

How much is all this costing the Colorado taxpayer?

In 1959, the services managed for the state by Blue Cross-Blue Shield came to \$6,526,188.69, plus \$131,194 for administration costs.

This meant that the administration costs ran about 2 per cent of the program's over-all expense.

For the item of Blue Cross-type hospital care, the state was charged just \$42,818 — a mere 0.8 per cent — for the processing of 21,409 hospital admissions.

It has been estimated that in New York, where the state handles all of the administration details for pensioners medical services, Colorado's \$6,526,188.69 outlay would have run up a paper work bill of more than \$700,000 — a far cry from the \$131,194 Colorado actually had to put out.

Doctor Paul Hartendorp, Director of Medical Service for the State Welfare Department said, "after two full years of trial, I'm convinced that our program is the best — and most effective in the nation."

"Blue Cross - Blue Shield does most of the paper work," he said, "but the Welfare Department still makes the decisions."

One dividend of the program has been a jump in pensioner morale.

Being assured of medical insurance-type protection has meant peace of mind to many a Colorado pensioner. Another morale builder is the privilege of being able to choose any hospital for medical care.

NEWS

ROTARY BOWL IS AWARDED TO DR. NEIDICH

Beaufort physician Dr. Sol Neidich on May 12 became the fourth person in a decade to receive the seldom-awarded Rotary Bowl.

The bowl, awarded by the Beaufort Rotary Club only when it decides there is a worthy candidate, was presented to Dr. Neidich by attorney Joab Dowling during the club's annual "Ladies Night".

Selected by a secret committee, Dr. Neidich was cited for his service to the city, county and state.

In presenting the award, Dowling noted the Beaufort physician served as campaign chairman for last year's United Fund drive that topped its goal by a comfortable margin.

He was credited with being instrumental in launching the Rotary Christmas welfare project and the club's annual vocational guidance program at the Beaufort High School.

He also serves on the Beaufort USO Club board of directors, a post he has held for some 10 years.

Dowling also pointed out that Dr. Neidich served three terms as chief of staff of the Beaufort Memorial Hospital, is a past president of the Coastal Medical Society and was appointed by Gov. E. F. Hollings to represent this county on the Alcoholic Commission of South Carolina.

A native of New York City, he was educated at

the University of South Carolina and the Medical College of South Carolina.

Except for World War II Army Air Corps service as a flight surgeon with the rank of major, Dr. Neidich has practiced in Beaufort since 1940.

DR. WIGHTMAN R. DUKE, SURGEON, JOINS ST. EUGENE HOSPITAL STAFF

Dr. Wightman R. Duke, surgeon, has joined the staff of St. Eugene Hospital in Dillon and has opened offices for the practice of medicine.

Dr. Duke comes to Dillon from Texarkana, Texas (and Arkansas), and has received a cordial welcome from members of the medical profession in the area.

Dr. Duke is a Fellow in the American College of Surgeons and a member of the American Medical Association, the Southeastern Surgical Congress, the Southern Medical Association and the state and local associations.

He was graduated with the A. B. Degree from Columbia University in New York and received his M. D. from Emory University in Atlanta, where he was highest honor graduate.

He was an officer in the Medical Corps of the U. S. Navy for 11 years, leaving the service with the rank of Commander, to do graduate work in surgery at the Mayo Clinic.

MEDICAL PANEL FEATURED

A panel of physicians, all members of the Greenwood Rotary Club, answered questions on medicine at a luncheon meeting of the Rotary Club at Greenwood recently.

Physicians on the panel were Dr. Guy Calvert, Dr. Stanley Baker, Jr., Dr. J. A. McQuown, Dr. William A. Klauber, Jr., Dr. W. P. Turner, Jr. and Dr. P. L. Bates, moderator. Dr. Lee Rodgers, local veterinary, and Preston Nesbit, administrator of Self Memorial Hospital also served as panel members.

Dr. K. N. Owens, obstetrician and gynecologist, and Dr. Niles A. Borop, Jr., will form a partnership in Aiken effective July 1, 1960 and operate from the offices presently used by Dr. Borop on Waterloo Street.

GRANTS AWARDED

Grants totaling more than \$200,000 have been awarded to the Medical College of South Carolina.

A two-year grant of \$35,800 was awarded by the American Cancer Society to Dr. H. R. Pratt-Thomas of the Department of Pathology to further the study of "Cervical Carcinogenesis (cancer) and Its Relationship to Smegma."

Dr. R. Randolph Bradham, assistant professor of surgery, was awarded \$7,500 for a year to study methods whereby thromboses may be dissolved. The United Health and Medical Research Foundation of South Carolina, Inc., made the award to Bradham.

Dr. Edwin Boyle, Jr. was awarded a three-year grant of \$28,658 a year for the study of cardiovascular disease in South Carolina.

Boyle is in the Department of Medicine. The grant was made by the Department of Health, Education and Welfare of the National Institutes of Health.

The Medical College was awarded a one-year grant of \$71,878.33 to improve and promote medical education generally. The grant was awarded by the American Medical Education Foundation.

The funds were made available by contributions of the medical profession such as medical auxiliaries, private practitioners and members of the Medical College staff.

DR. BRICE OPENS OFFICE IN ROCK HILL

Dr. Joe M. Brice, Jr., an orthopedic surgeon, is establishing an office at 144 Sedgewood Drive in Rock Hill. He is a native of Kingstree and son of Dr. and Mrs. J. M. Brice, Sr. He attended public schools in Kingstree and is a 1950 graduate of The Citadel. He graduated from the Medical College of South Carolina in Charleston in 1954 and interned at Cook County Hospital in Chicago, Ill.

He has taken specialty training at Grady Memorial Hospital in Atlanta, Ga., and Medical College of Virginia Hospital and Crippled Children's Hospital in Richmond, Va.

HARDEEVILLE HEALTH CENTER HAS OPEN HOUSE

Persons visiting the new auxiliary Health Center in

Hardeeville, Friday, April 23, during "Open House" were high in praise of this modern and well equipped health facility.

Constructed of brick with wrought iron trim it is an attractive addition to the Town of Hardeeville. It is complete with waiting room space large enough to seat 40 persons comfortably, two rest rooms, utility room, dressing room, examining room, treatment and conference room.

Dr. T. B. Carroll, Jr. is part-time Clinician.

COL. CHARLES TAKES HOSPITAL EDUCATION POST

J. M. Daniel, Superintendent of the Columbia Hospital of Richland County, has announced that the Board of Trustees of the hospital has approved the appointment of Col. Roland K. Charles, Jr., as Director of Medical Education. Dr. Charles will assume his position at the hospital July 1, 1960.

In this new position Col. Charles will organize, coordinate, and promote the continued growth and development of the educational activity of the hospital in the medical field. The Columbia Hospital is approved by the Council on Medical Education of the AMA for the training of internes and for the training of residents in the specialties of General Surgery, Obstetrics and Gynecology, Orthopedics, Pediatrics and Internal Medicine.

He is a native of Timmonsville, and received his AB degree from Wake Forest College, N. C., and his medical degree from Jefferson Medical College, Philadelphia, Pa. Prior to military service, Dr. Charles served on the staff at Saunders Memorial Hospital in Florence for four years.

At the recent annual meeting of the Palmetto Medical, Dental and Pharmaceutical Association held at Atlantic Beach, May 10-12, speakers included: Dr. Carl Greene, Columbia; Dr. J. R. Paul, Charleston, and Dr. Arthur V. Williams, Charleston.

NURSING CARE CENTER BUILT NEAR COLUMBIA

The first unit of a million-dollar nursing care center opened near Columbia its president and medical director, Dr. J. William Pitts, has announced.

Pine Lake's initial unit, a 32-bed, \$200,000 building overlooking landscaped grounds and private lake, will receive persons coping with an alcohol, narcotic, or mental health problem.

"Pine Lake will fill an acute need for an institution of the highest standards," Dr. Pitts said. "We plan to stress the value of wholesome recreation — fishing, golf, horseback riding or hiking — in the rehabilitation of our patients."

Now in an advanced stage of planning is a 100-bed general nursing care facility. An announcement about this will be forthcoming in a few months, Pitts said.

Design of the building was worked out in cooperation with Dr. W. P. Beckman, director of the S. C.

Mental Health Commission, and with the advice of the hospital planning unit of the State Board of Health.



A portrait of Dr. Thomas Antley Pitts of Columbia, chairman of the board of trustees of the Medical College of South Carolina since 1941 and a member of the board since 1930, was unveiled in an informal ceremony held June 2nd in the amphitheater of the Medical College Hospital. The portrait of Dr. Pitts, who graduated from the Medical College in 1916, will be hung in the Medical College Hospital which was built while he was chairman of the board.

Members of the board of trustees, faculty and staff of the Medical College and personal friends of Dr. Pitts commissioned the portrait, which was presented to the institution by Dr. J. Decherd Guess of Greenville, a member of the board of trustees. Dr. Kenneth M. Lynch, president of the Medical College, accepted the portrait for the institution.

The South Carolina Pediatric Society held a business meeting in Myrtle Beach on May 18th. Officers elected for the coming year are: Drs. Kenneth H. Herbert, Charleston, President; Casper E. Wiggins, Greenwood, Vice President; and Howard B. Smith, Conway, Secretary-Treasurer.

Dr. A. R. Johnston of St. George was elected second vice-president of the Association of Surgeons of the Southern Railway System at a recent meeting of the Association.

FROM THE PAPERS

DR. LYNCH RETIRES

In the 47 years since Dr. Kenneth M. Lynch first came from Texas to the faculty of the Medical College of South Carolina, medicine has undergone many changes. So has the medical college. In both, Dr. Lynch has played a prominent role.

Under his direction, the college has expanded both in number of students and in facilities. The big Medical College Hospital is due almost entirely to insistence by Dr. Lynch that the college should have its own hospital instead of depending, as in the past, on the community hospital for teaching material. The State of South Carolina invested heavily in this building on faith in Dr. Lynch's policies.

Succeeding him as president will be Dr. John T. Cuttino, a graduate of the Medical College who returned to Charleston after military service in World War II to join the medical faculty. He holds the office of dean of the School of Medicine and executive vice president of the college. Dr. Cuttino is thoroughly familiar with the administration and we wish him well in assuming his new duties. To Dr. Lynch we express the thank of the public for many years of service, and the good wishes of South Carolina citizens for long life and good health in retirement.

News and Courier

MEDICAL LEADER

As spokesman for the medical profession in this state, the president of the South Carolina Medical Association plays an important role in public affairs. He may be called on to express views on state legislation concerning health and medical care. Inasmuch as the medical men he represents are substantial citizens in their communities, his words bear weight in public deliberations.

We make these comments in connection with the installation Tuesday of Dr. Joseph P. Cain, Jr. of Mullins as the new president of the state medical association. Dr. Cain is a man with an established medical background. Several generations of Cains have practiced and taught medicine in South Carolina and helped raise professional standards.

We are confident that in assuming his new duties Dr. Cain will carry on a notable tradition of medical service to his state.

News and Courier

DR. H. GRADY CALLISON,
DEAR GRADY:

Few Andersonians have had more useful or faithful

careers than the one you have established in 36 years of public health work. You have seen public health work grow from infancy to the vital position it now holds in our state and county. And you have made a great contribution to that progress. Many thanks and continued success to you.

COLONEL ANDERSON
The Anderson Mail

THE SOUTH CAROLINA EYE BANK

South Carolina has joined other areas in the creation of an eye bank whose major purpose is that of supplying corneal material for transplants. The corneal material is available for the use of ophthalmologists in the state and other eye banks when needed and available. In addition to supplying corneal material, the eye bank is supplying vitreous for implantations and, where possible, eyes for basic research and eye pathology.

The eye bank was created three years ago by a committee from the Lions Clubs of the state working with a committee from the South Carolina Society of Ophthalmology and Otolaryngology. This culminated several years of planning which included the passage of permissive legislation whereby donation of one's eyes while living to be effective immediately after death was adopted. The operation of other eye banks was studied and visits were made to the North Carolina Eye Bank in Winston-Salem, North Carolina. Plans for the creation of the bank were discussed with Dr. Lynch of the Medical College of South Carolina, looking for the advancement of the training in ophthalmology at the college and for the advancement of knowledge of eye pathology in the state.

Although statewide in scope of its operation the eye bank is centrally located in Columbia. It has representatives throughout the state and equipment for the enucleation and transportation of eyes strategically located at various places over the state.

The basic operation of the eye bank is that of a clearing house for the channeling of information. It maintains a twenty-four hour answering service to receive calls. It maintains a file of donors who have signed forms donating their eyes to the bank. It receives requests from doctors for corneal material and vitreous. The eye bank handles the details for the enucleation and transportation of the eyes by contact with ophthalmologists.

Comparatively speaking, the South Carolina Eye Bank is young in its existence and operation. Since its creation it has supplied corneal material for 25 corneal transplants and vitreous for 8 implantations.

During the early months of its operation the eye bank had to rely exclusively on eyes received from other eye banks. These eyes were received from the Boston Eye Bank, the Eye Bank for Restoring Sight, New York, and the Sight Conservation Society of Northeastern New York, Schenectady. The last named

bank was most cooperative and was our principal benefactor in the supplying of corneal material.

Reports have not been requested or received from ophthalmologists giving the results of the operations which have been performed; however, from the reports which have been received, it would appear that in most instances the post-operative recovery has been satisfactory.

In addition to providing corneal and vitreous material, the eye bank was created to supply eyes to be used in basic research. Those phases of research with which the bank is most familiar have been in methods to preserve corneal material.

As a result of such research, there has been developed a method by which corneal material and also vitreous can be preserved. This procedure is commonly referred to as a "dry freeze" process. Vitreous, of course, can be stored even at room temperature without losing its qualities or can be kept under refrigeration for great lengths of time; however, the cornea must be preserved through this or some similar process or used immediately.

Corneas which have been preserved are used basically for preservation of the eye in cases where immediate transplant is necessary. They are also used for lamella (partial-thickness) grafts; however, fresh corneas are still preferable for lamella transplants and are required for full-thickness grafts.

Recently, the North Carolina Eye Bank in Winston-Salem purchased the necessary equipment and provided facilities and personnel for preserving corneas. Through its affiliation with the North Carolina Eye Bank, our organization has been provided with the use of these facilities for a nominal fee. To date, the bank has processed one set of corneas and they are on hand for use when an emergency arises.

As stated in the opening remarks the eye bank desires to assist in the training of ophthalmologists and the furnishing of eyes for pathological purposes to the Medical College. As eyes become more readily available, this purpose may be realized. At present the eyes are not being received in sufficient quantity to aid materially in this phase of the program; however, we of the eye bank feel that with the establishment of an eye bank more eyes will be available when its purposes are more generally known. With more eyes available and with increased laboratory work on research and eye pathology at the Medical College the entire field of ophthalmology in South Carolina will be advanced.

We of the eye bank wish to assist all doctors in the state, not only the ophthalmologists with whom we are more closely related.

The continued interest and support of the entire medical profession is earnestly requested. An undertaking of this nature can only succeed with the help of all citizens both professional and lay. Your inquiries are invited. Please call on us to render any assistance which we may give.

ANNOUNCEMENTS

The 1960 Annual Meeting of the Southern Trudeau Society (and the Southern Tuberculosis Conference) will be held on September 14, 15, and 16, 1960, at the Hotel Francis Marion, in Charleston, South Carolina.

The Fourth National Cancer Conference will be held at the University of Minnesota, Minneapolis, September 13-15, 1960. The theme of the Conference is "Changing Concepts Concerning Cancer." The Conference is sponsored jointly by the American Cancer Society and the National Cancer Institute of the Public Health Service, Department of Health, Education, and Welfare.

Copies of the Conference program and registration cards may be obtained from the National Cancer Conference Coordinator, American Cancer Society, 521 West 57th Street, New York 19, N. Y.

The tenth Biennial Southeastern States Cancer Seminar for Physicians will be held at the Cherry Plaza Hotel, in Orlando, Florida, November 16-18, 1960. The theme "New Horizons of Cancer Research and Therapy" will feature an outstanding faculty of fourteen nationally prominent guest speakers.

This Seminar is being presented by the Orange County Medical Society in cooperation with the Florida Medical Association and supported jointly by the Florida State Board of Health and the American Cancer Society, Florida Division, Inc. There is no registration fee.

For advance reservations or further information, contact 1960 Cancer Seminar Committee, 17 Lake Street, Orlando Florida.

TENNESSEE VALLEY MEDICAL ASSEMBLY, Read House, Chattanooga, Tenn., September 26-27, 1960. Dr. Robert A. Waters, 109 Medical Arts Building, Chattanooga, Tennessee, Chairman.

GREENWOOD SEMINAR

The Annual Greenwood Seminar will be held at the Self Memorial Hospital on Wednesday, August 10, 1960. The program will be as follows:

Dr. J. R. Heller—"Cancer Research and Modern Therapy of Malignancies."

Dr. Thomas A. Stamey—"Present Concepts of Renal Hypertension."

Dr. Robert A. Conard—"Diagnosis and Treatment of Radiation Sickness."

Dr. Frank F. Lamons—"Orthodontics, Its Place in Today's Practice."

There will also be several five minute papers presented by members of the Staff of Self Memorial Hospital.

Dr. Heller was recently appointed Head of The Memorial Hospital, New York.

Dr. Conard was responsible for the study of the Marshallese and Americans accidentally exposed to fallout radiation in 1954. Since 1955 he has been Associate Physician Scientist with the Brookhaven National Laboratory and has continued his annual surveys of those exposed to fallout in 1954.

Dr. Thomas Stamey is Assistant Professor of Urology, Urological Department, John Hopkins Hospital.

Dr. Frank Lamons is Professor of Orthodontics and Chairman of Orthodontic Department, Emory University School of Dentistry.

CENTER TO CARE FOR ALCOHOLICS

Florence's role as one of the leading medical centers of the Carolinas will be strengthened during the future with the construction of the South Carolina Alcohol Rehabilitation Center.

Plans for the center have been drawn. Construction awaits only state appropriation of \$75,000 to add to a \$75,000 appropriation made in 1958. This sum is to be matched by a \$150,000 appropriation of the U. S. Government.

The new center is to be located on the Florence-Darlington dual-lane highway in the vicinity of the Florence-Darlington Tuberculosis Sanatorium, and the Darlington-Florence Mental Health Clinic.

DEATHS

DR. J. H. CANNON

Dr. Joseph Henry Cannon, heart specialist and founder of the first heart clinic in Charleston, died at a local hospital May 22. He was 74.

Dr. Cannon was born in Charleston in 1886. Dr. Cannon was graduated from the Medical College of South Carolina in 1912.

In 1930, Dr. Cannon established the first Charleston clinic devoted especially to the diagnosis and treatment of heart disease at Roper Hospital. In conjunction with his work in heart ailments Dr. Cannon introduced the first electrocardiograph in Charleston.

Dr. Cannon was for many years a delegate to the American Medical Association from the South Carolina Medical Association. He was emeritus clinical professor of medicine at the Medical College of S. C.

He was president of the Medical Society of South Carolina from 1940 to 1941 and was treasurer of that organization for many years. He was a past master of Orange Lodge 14, AFM and was an honorary member of the Country Club of Charleston. He was retired as a lieutenant commander in the U. S. Naval Reserve.

Dr. Cannon's membership in professional organizations included the American Heart Association, American Medical Association, American College of Physicians, the Widows and Orphans Society, Medical Society of S. C., Charleston County Medical Society and the S. C. Medical Association.

DR. E. T. KELLEY

Dr. Edward Theron Kelley, 73, physician and surgeon of Georgetown died Monday, May 16th at his residence.

Dr. Kelley was born October 10, 1886, in Lee County near Bishopville. He was graduated from the Medical College of South Carolina in 1908 and began practice in Kingstree shortly afterward. He later founded Kelley Memorial Hospital in Kingstree and was surgeon there until coming to Georgetown in 1947. He and his son, the late Dr. James Aleck Kelley, built and operated Kelley Clinic.

Dr. Kelley was a fellow of the American College of Surgeons, a member of the Tri-State Medical Society, and other professional groups. He was a Mason.

While living in Kingstree, he was active in civic and fraternal organizations.

McCormick finally has its second doctor.

Dr. C. R. Strom, Jr. will move to McCormick from Cliffside, N. C., as soon as a residence is available and will take over the building occupied by the late Dr. C. F. Workman.

A native of McCormick and a graduate of McCormick High School, Dr. Strom was graduated from the University of Georgia and went into the newspaper profession. After gaining a pre-medicine degree at Guilford College, N. C., he was graduated from the Medical College of South Carolina.

DR. LEWIN OPENS OFFICE AT CRESCENT

Dr. B. Read Lewin, frequent visitor to the Grand Strand, has taken up permanent residence at Crescent Beach and has opened offices for local practice. A native of New Hampshire, Dr. Lewin is aged 52, a graduate of McGill University of Montreal, Canada, and holds a Fellowship in the American College of Surgeons. He served his internship at Kings County Hospital, Brooklyn, N. Y. and did resident and fellowship work at Presbyterian Hospital, Newark, N. Y. A specialist in surgery, Dr. Lewin was recently approved as a full fledged staff member of the Loris Hospital.

BOOK REVIEWS

PSYCHOANALYSIS AND HUMAN VALUES. (Science and Psychoanalysis. Volume III) Edited by Jules H. Masserman, M. D., Editor. 367 pages. Grune & Stratton, New York. 1960. \$11.00.

This book represents the third volume of study in the three years of the existence of the Academy of Psychoanalysis. It is a beginning study of the relationship of the personal, moral, and ethical feelings as related to psychiatric disease. There are many writers from the various non-Freudian training institutes of psychoanalysis expressing their ideas as to how the goals of psychoanalytic therapy can and must be related to more than just symptom-removal. Various

articles trace the development of psychoanalytic therapy through the phases of symptom removal, authoritarian doctor-patient relationship, and the understanding of conscience formation (expressed formerly as the "super ego.")

This book, in many articles, shows the important present phase of what is called "value orientation" as it is worked out in therapy. In other words, many studies have previously indicated that what a patient begins to live by, in the various sectors of his life, may be a reflection of what the psychoanalyst thinks and feels. However it is well pointed out that in the proper doctor-patient relationship in psychoanalytic therapy, the doctor must be as aware of his own personal values as he is of teaching the patient to develop his values quite apart from and separate from the personal values of the analyst himself. In fact, as one article points out in the book, the major or highest goal in therapy should consist of finding and developing a set of personal values in the patient that is forged and developed in a unique personal setting, apart from what external society superficially believes. But most importantly, it is to be able to find out that he has certain personal values that are consistent with and are reinforced by other similar values that do exist in our society, even though it is not found in the majority of people.

This book is, in a way, somewhat technical but is also sociologically acceptable, since it relates the individual to finding some validation of his values as they exist in some parts of our society, and emphasizes the importance of solid values of thinking, feeling and behavior, rather than finding security in these values only if they exist in the conventional majority.

The articles present a new approach to what can be called today "the science of morality." Although the goals in this are admittedly high, it does at least indicate that there is scientific validity in finding out what morality is.

Norton Williams, M. D.

CURRENT APPROACHES TO PSYCHOANALYSIS. Edited by Paul H. Hoch, M. D. and Joseph Zubin, Ph. D. 191 pages. Grune & Stratton, New York 1960. Price \$6.50.

This book is a compilation of the Annual Meeting of the American Psychopathological Association. Essentially, this book is an attempt to bring together the various so-called newer schools of psychoanalytic thought. They are represented mainly by 4 groups from 4 schools of psychoanalytic thought, exclusive of the so-called classic Freudian school. These groups are known as (1) the Sandor Rado "adaptational" approach; (2) The Flower-Fifth Avenue Medical Group, which emphasizes responses to cultural factors; (3) the Sullivan Group, represented best by Dr. Clara Thompson, whose major emphasis is on interpersonal relationships; and the Karen Horney group, which deals with the process of "self-realization."

In evaluating these groups it is pretty clear that neither one has, or claims to have, exclusive monopoly on any one of these processes of personality development and its deviations. Each have taken an important part of the total personality development in an attempt to elaborate and extend more completely the understanding of the total individual psychologically and in his responses to himself and his world around him.

Actually, this book is not an attempt to find a more clear pattern of common denominator but to emphasize more fully each phase of personality development. The adaptational approach merely means an attempt to take the gross, often overly strong feelings of the early childhood based on approval and disappointment, and place them on a more adult level where approval or disapproval does not form the main content of emotional feelings. The so-called cultural approach takes into consideration the importance of our own traditional total life experiences. Therefore, it attempts to place in better proportion that part of our life that deals with what we have learned from parents and from other significant people in our lives, without overemphasizing their importance. The interpersonal theory emphasizes the significance of relatedness to other human beings and how the richness and variety of human nature is important to our own personal experiences.

The theory of the self emphasizes the importance of relationship to oneself and the ability to take from the historical experiences of life (early childhood and cultural factors) and to make them an integral part of a person's own life in the full context of what he really is as an adult. This book emphasizes the importance of the therapist's working knowledge with all theories of human behavior so that he can be flexible enough to know what phase of personality difficulty needs the greatest concentrated effort. The book is of considerable value to all doctors of medicine since it tends to establish therapeutic positions, much as to the way different types of drugs are used for different clinical syndromes.

Lastly, this book shows that psychoanalysts do not have to prove the exclusiveness of their own therapeutic theory in order to feel scientifically secure.

Norton Williams, M. D.

BABIES BY CHOICE OR BY CHANCE. Alan F. Guttmacher, M. D. Doubleday & Company, Garden

City, New York. Price \$3.95.

The author of this book has long voiced, in scientific meetings, the views he now expresses for the general public.

He is well known not only as an obstetrician and gynecologist, but particularly for his interest in infertility and planned parenthood. The book is written primarily for the laity in appropriate terminology. Dr. Guttmacher writes as frankly as he speaks—which is quite frankly. In various pages the book appears to be extracts of Dr. Guttmacher's autobiography. His forthright views and recommendations on birth control and artificial insemination will offend some.

His impressive presentation of the world's "population explosion", should be thought-provoking to everyone. The chapter on therapeutic abortion is primarily of medical interest; while the one on the tragedies of criminal abortion affords valuable education for the layman.

In my opinion, this is a controversial medical book, the recommendation of which for patient reading should be selective.

J. Richard Sosnowski, M. D.

CURRENT THERAPY-1960, Edited by Howard F. Conn, M. D. W. B. Saunders Company, Philadelphia, 1960. Price: \$12.00.

Any book running to twelve editions must be good. This annual volume has apparently established itself very well with the physicians of the country. Each year's production is a new edition in a sense since there are many new writers added as older writers are replaced, and a constant rotation keeps the book fresh and informative. The articles represent the therapy currently used by men of high standing in the medical profession. It is not the type of thing which reports only recent advances, as quite possibly some of the current therapy may not be based on the most recent advances, or suspected advances.

Altogether this should be an extremely valuable book for the practitioner. It is in pleasing format, and the index and references are well arranged. The reviewer notes two South Carolinians among the rather numerous contributors—Dr. Lawrence Hester and Dr. John van de Erve, both of Charleston.

This book can be recommended without reservation.

JIW

WOMAN'S AUXILIARY

SOUTH CAROLINA MEDICAL ASSOCIATION

President: Mrs. George Smith, Columbia, S. C.

Recording Secretary: Mrs. George Dawson, Florence, S. C.

ANNUAL REPORT—House of Delegates

May 19, 1960

As President of the Woman's Auxiliary to the South Carolina Medical Association I proudly present our report for the year. We have had a splendid year, and each individual chairman has certainly done a superb job.

Contributions for AMEF this year have totaled \$1,713.37 which is an increase of \$251.16 over last year; \$96.75 was contributed by our State Board at the Fall Executive Board Meeting. We had some excellent projects throughout the state such as fashion shows, barbecues, Doctors' Day celebrations, memorials, bake sales, dish towel sales, and selling of spices and vanilla. According to the membership, Horry, Pickens, Spartanburg, and Richland will receive awards for highest per capita contribution—Spartanburg for the largest contribution—and Richland showing the greatest increase over last year.

Recruitment of both nurses and in allied medical fields has always been one of South Carolina's outstanding state projects. There are over 30 paramedical or future nurses clubs in South Carolina with a membership of 700. The change from Nurse Recruitment to Paramedical Recruitment has had a good start in the State, and I feel sure that all counties will participate soon. This year a wonderful program was planned for the Future Nurses Rally with close to 300 registrations to be held at Winthrop College in Rock Hill. It had to be cancelled due to the flu epidemic. The Student Loan Fund has suddenly become very active with three accepted applications at \$1,000.00 per year.

Safety held an important spot with many county auxiliaries this year. Thirteen of our 18 auxiliaries responded to the Safety Questionnaire mailed March 1, 1960. A film, "Devil Take Us" was shown successfully in five high schools. Over 3,000 viewed this film. 6,000 pamphlets on Digest of South Carolina Safe Driving Rules and "New Point System for Traffic Law Violations" were given high school student and manufacturing employees. One auxiliary had a booth in the County Fair with safety displays, posters, etc. One other auxiliary had a poison shadow box for display in hospital.

South Carolina has gone all out to carry out the three projects set up by our AMA president, Mrs. Frank Gastineau—#1 Community Service, #2 AMEF, #3 Legislation.

As far as legislation goes, we have written 85 letters to our representatives, congressmen, and senators urging support of the Jenkins-Keogh Bill and non-support of the Forand Bill. Other organizations contacted concerning these bills were Federated

Clubs, Junior Leagues, Garden Clubs, Church Groups, and Book Clubs. One auxiliary had personal contact with two representatives and their wives. Vice-President Nixon received a telegram from our State Auxiliary. A resolution from the State Medical Auxiliary is on record opposing the Forand Bill.

Community Service, National's #1 project, was most outstanding in South Carolina. A total of 63,962 hours was spent in Community Service throughout the state with about one half of the membership reporting. I feel that if the entire membership had reported it would have certainly reached 100,000 hours. This work included United Fund, Cancer Drive, Polio Drive, Heart Drive, Girl Scouts, Salvation Army, King's Daughters, Muscular Dystrophy, Family Service Association, PTA, Crippled Children, YMCA, YWCA, Tuberculosis, League of Women Voters, Mental Health, Nurse Recruitment, and in many capacities with the church.

During 1959-60 our membership increased from 825 members to 865 which is an increase of 40 members. We have 24 members at large and 3 deceased members.

County auxiliaries worked with Mental Health and Civil Defense during the year. Six counties helped with Mental Health problems. During Mental Health week 18 auxiliary members of a local auxiliary registered guests at the South Carolina State Hospital. Another auxiliary gave \$25.00 for the winning essay on Mental Health. All county auxiliaries reported co-operation with their local Civil Defense organization. Twelve auxiliary members reported having taken a course in Home Nursing and 26 reported as having taken courses in First Aid. Several of our members attended the National Security Seminar in Greenville.

We have a total of 150 subscriptions to National Bulletin from 17 counties.

I must mention some of our outstanding voluntary service and philanthropic work. Sample drugs are collected from doctors for use in out-patient clinics; children on the Pediatric Ward are read to weekly; auxiliary members serve as Gray Ladies as well as work in hospital snack bars. I feel that the most outstanding work along this line has been one county's training Future Nurse Club members as Nurse's Aids with auxiliary furnishing uniforms, sleeve bands, pins, and caps. There are 40 girls in this class. One auxiliary brought in \$2,790.00 in nickels and dimes by selling Easter lilies for the Crippled Children's Society.

Many activities took place to celebrate Doctors' Day such as coffee parties, AMEF donations, giving red carnations to the doctors, suppers, etc.

Fortunately, I was able to accept every invitation

received by county auxiliaries, and it was truly heart-warming to visit each one and see the various interests in different parts of the state. It is a year of my life that I shall always cherish.

I wish to take this opportunity to tell each and every member of the South Carolina Medical Auxiliary how proud I feel to have completed another successful year in Medical Auxiliary work.

Mrs. John G. Ramsbottom, President

Respectfully submitted,

Five counties sponsored the Essay Contest this year, resulting in a first place state Winner, Greenville and a third place state winner, Pee Dee. Greenville won eighth place nationally.

OFFICERS OF WOMAN'S AUXILIARY

President

Mrs. George W. Smith, Jr., Columbia

TENTH ANNUAL POSTGRADUATE OBSTETRIC- PEDIATRIC SEMINAR ELLINOR VILLAGE, FLORIDA TENTATIVE PROGRAM

Thursday—August 18, 1960—Helen W. Bellhouse,
M. D., presiding

7:15 A. M. Dutch Treat Buffet Breakfast

8:45 A. M. Toxemia—Treatment of the Underlying Disease

Speaker: Frank A. Finnerty, Jr., M. D.

Discusser: Harry Prystowsky, M. D.

Cause of Death in Toxemia as Found at Autopsy

Speaker: E. J. Dennis, M. D.

Discusser: Robert A. Ross, M. D.

Open Discussion

Care of Newborn in Last Trimester Complications

Speaker: Mildred Stahlman, M. D.

Discusser: Andrew E. Lorincz, M. D.

Open Discussion

The Effects of Toxemia of Pregnancy on the Newborn Infant

Speaker: Gerard Odell, M. D.

Discusser: Warren W. Quillian, M. D.

Open Discussion

1:00 P. M. Adjournment

Friday—August 19—Harold A. Klingler, M. D.,
presiding

7:15 A. M. Dutch Treat Buffet Breakfast

Vaginal Examination at Term

Speaker: Robert A. Ross, M. D.

Discusser:

Open Discussion

Routine Postpartum Papanicolaou Smears

Vice-Presidents

Mesdames McMurry Wilkins, Jr., Greenville; M. E. Hutchinson, Columbia; Robert L. Sanders, Columbia; and Edwin L. Wallace, III, Barnwell.

Recording Secretary

Mrs. George R. Dawson, Jr., Florence

Treasurer

Mrs. L. Hayne Taylor, Jr., Greenville

Historian

Mrs. S. Edward Izard, Charleston

President-elect

Mrs. John S. Cuttino, Charleston

Elected as delegates to A. M. A. Woman's Auxiliary meeting to be held in conjunction with A. M. A. Meeting in Miami Beach: Mrs. John G. Ramsbottom, Mrs. George W. Smith, Mrs. R. L. Crawford, Mrs. Robert T. Jeanes and Mrs. Ralph Baker.

Speaker: Harry Prystowsky, M. D.

Discusser: Luella Klein, M. D.

Open Discussion

Respiratory Emergencies of the Newborn

Speaker: Warren W. Quillian, M. D.

Open Discussion

Refreshment break

Respiratory Distress Syndrome

Speaker: Mildred Stahlman, M. D.

Open Discussion

Obstetric-Pediatric Panel—Anoxia, including Resuscitation of the Stillborn

Moderator: Harry Prystowsky, M. D.

Panelists: Drs. Odell, Stahlman, Quillian, Dennis, Ross, Ingram

4:00 P. M. Adjournment

Saturday—August 20—Hilla Sheriff, M. D.,
presiding

7:30 A. M. Dutch Treat Buffet Breakfast

Pediatric Panel—Bilirubinemia—A persistent Problem in the Newborn

Moderator: Warren W. Quillian, M. D.

Panelists: Drs. Odell and Stahlman

Preventive Obstetrics

Speaker: Luella Klein, M. D.

Discusser: J. M. Ingram, Jr., M. D.

Open Discussion

Coffee Break

Obstetric Panel—Indications for Interruption of Pregnancy and for Sterilization

Moderator: Robert A. Ross, M. D.

Panelists: Drs. Dennis, Finnerty, Ingram, Klein, Prystowsky

12:00 A. M. Adjournment

WATCH OUT!

It is quite possible the powers that be in Washington have more than one reason for complaining about the prices of drugs. Senator Estes Kefauver's drug price investigating subcommittee would have us believe that the government's sole interest is "simply with the price of drugs—a price which must be paid by someone under any system of medical care". I think there is a psychological reason which they hope to keep under cover. This Senate antitrust investigation is just another cunning approach in the attempt to slip socialized medicine in at the back door. It appears to me that Mr. Kefauver almost gave this fact away in his opening statement when he said: "It is not the purpose of these hearings to question in any way the American system of private medical practice." I react to this statement in the same manner I would if a small boy should rush into my office and exclaim: "Doctor, someone batted a baseball through your back window—and I don't want you to think that I did it."

If these investigators' thoughts were just in the drug field, they should also be concerned about quality as well as price. They certainly have shown a lack of interest in the cost of pharmaceutical research and manufacturing, and without research drugs would soon degrade in both quality and quantity. The Senator's line of reasoning in advocating that druggists be allowed to use generic instead of brand names, would throw the drug business into a tail spin within a short time. If one company spends a million dollars to produce a new drug, and another concern is allowed to copy the formula, pay none of the research cost, and market the product at a low price, the results would be disastrous. The better firms would go broke, initiative to find new drugs would be smothered and we would find ourselves advancing in reverse—back towards the "calomel and castor oil days."

I feel that these governmental probes are motivated, primarily, for publicity. If they can attract enough attention by their investigations of the major drug manufacturing firms, and lead the American people into believing that the prices of drugs are too high, it might be possible to gain a large number of sympathetic listeners.

They hope to stir up enough interest in the drug controversy to swing the spotlight away from the doctors for a while, give us a breathing spell, make us feel complacent and lessen our vigil against legislation like the Forand bill. It is their wish that we don't get wise to their twofold purpose of these investigations in relation to the Forand bill itself. First, they will attempt to convince the lay public that older people, on social security, will not be able to pay the high drug prices—and that the government should step in to help. Second, if these tactics could get a Forand type of legislation passed without enough medical publicity to stir up strong opposition—they would be in position to widen social security to cover everybody. Then we would have socialized medicine

under another name.

People, consciously, or unconsciously, associate drugs and physicians together. An aroused populace against drug prices would not be too friendly towards the medical profession. Such a situation would gain recruits for a more effective battle against the free practice of medicine. While we sit on the side lines, apparently unmolested, and watch the steam roller attempt to crush the drug firms, we must remain alert. We could get caught napping like Hitler did one time during World War II—when the Allied soldiers were issued heavy, long-handled underwear. As soon as the Germans got wind of it, they rushed up to Norway while our troops poured into Africa. It behooves us to watch out for all sorts of misleading tactics, because this drug battle is only a sham attack. The medical profession is their chief objective. They hope to find time to reorganize their forces, turn upon us without warning and launch a surprise attack where and when we might least expect it.

F. Clyde Bedsaul, M. D.

Reprinted from *Virginia Medical Monthly*, 87:175, April, 1960.


The Journal has received a yellowed and aged clipping on which someone has written "Big Lie"—probably he was right. At any rate, here is the clipping:

A REMARKABLE BIRTH

A Woman Supposed to Be Dead Becomes the Mother of a Child

COLUMBLA, S. C., Nov. 25 (Special).—An extraordinary occurrence is reported from Summertown, Clarendon County. A colored girl, 17 years old, who had been ill several days, died last Wednesday. The body was properly prepared and dressed for burial and placed in a coffin, the negroes of the neighborhood holding their customary noisy "wake" over the corpse all through Wednesday night. The funeral services were held in the colored church on Thursday afternoon and the body was to be interred in a graveyard about two miles distant. When the cortage had reached a point within fifty yards of the cemetery the pall-bearers were startled by a crying noise somewhat resembling the mewling of a cat, apparently emanating from the coffin. The procession was halted and after considerable discussion it was resolved that the coffin should be opened.

Upon removing the lid it was found, to the great consternation of the funeral party, that the woman was alive, but unconscious, and that a newborn babe shared with her the narrow bed. Several of the pall-bearers and mourners were terror-stricken and fled. Those who remained, however, ministered to the wants of the woman and her infant and in a short time both were taken to a neighboring house where they received kindly and necessary attention. At last accounts the mother was doing well, there being every indication of her complete recovery, whilst the infant is hearty and robust and is flourishing as well as any pickaninny born under ordinary conditions and circumstances.



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signs of
anxiety-tension
specify

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brand of thiopropazate dihydrochloride

for rapid relief of anxiety manifestations

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with low dosage: Only one 2, 5 or 10 mg. tablet t.i.d. *with relative safety:* Evidence indicates Dartal is not icterogenic.

Clinical reports on Dartal: 1. Edisen, C. B., and Samuels, A. S.: A.M.A. Arch. Neurol. & Psychiat. 80:481 (Oct.) 1958.
2. Ferrand, P. T.: Minnesota Med. 41:853 (Dec.) 1958.
3. Mathews, F. P.: Am. J. Psychiat. 114:1034 (May) 1958.

SEARLE

The Diabetic's Handbook, 2d Edition. By Anthony M. Sindoni, Jr., M. D. Price, \$4.50. Pp. 285. The Ronald Press Co., 15 E. 26th St., New York 10, 1959.

It was a wild, tempestuous night toward the close of November. Outside, the wind howled down Baker Street while the rain beat fiercely against the windows. Sherlock Holmes and I had sat in silence all the evening, he deep in a volume upon diabetes which had been sent to me for review, I dreaming over my Afghan experiences. Finally, Holmes passed me the book and drew his chair closer to the fire. While I examined the work, he smoked another pipe of his shag tobacco.

"Well, Watson, what do you make of it?"

"I think," said I, following as far as I could the methods of my companion, "that the author has written a handbook for the patient. In simple, easily understood language, he outlines for the diabetic the latest knowledge he must have and the exact instructions he must follow in order to lead the most normal life possible. The author is one of America's leading experts on diabetes and has collaborated with eighteen internationally known physicians from five Philadelphia medical schools. You seem surprised, Holmes, with the rapidity of my observations. I followed your own methods, of course, but was able to obtain the information quickly from the dust cover of the book."

"As I observed," said Holmes.

"I therefore conclude," I continued, "that the book is authoritative and clear, and that this is an excellent volume for the medical man to recommend to his patients."

"Really, Watson, you excell yourself," said Holmes, "I am bound to say that your opinions stimulate me."

"Has anything escaped me?" I asked with some self-importance. "I trust that there is nothing of consequence which I have overlooked?"

"I am afraid, my dear Watson, that most of your conclusions were erroneous. When I said that you stimulated me I meant, to be frank, that in noting your fallacies I have occasionally been guided toward the truth."

"Then do you mean to tell me, Holmes, that this book is of no value?"

"I did not say that, Watson, I merely observed that you have based your conclusions upon the unreliable data of a dust cover. The book is clearly of some value, since this is the 2nd Edition. However, I think that the writing is so devious as to confuse those of limited powers, such as our acquaintances Lestrade or Gregson. I note that there are some factual errors, Watson. On page 14, it is said that the composition of insulin is unknown, with which I fancy Sanger might disagree. On page 155, the patient is recommended to test the urine at least twice a week, a practice which leaves something to be desired. Although the book was published in 1959, there is no mention of Clinitest tablets, which I have heard you recommend. These errors will not dismay the reader

who rates the spirit higher than the letter. But, my dear Watson, it is the spirit of the book which appears to me to be lacking, for it has seemed to me that the keynotes of teaching the laity are simplicity and encouragement. Much of the technical information contained in this volume may bore or even misguide your patients."

"But, Holmes, the dust cover———"

"Simplicity itself, Watson. I have always attempted to show you that you should check your data. I must confess that I am myself the author of a trifling monograph upon dust covers. In it, I enumerate 127 different forms of book jackets, with colored plates illustrating the methods of the various publishing houses. Dust covers continually turn up in reference to book reviews and are sometimes of supreme importance as a clue. Did you confirm that the writing was simple and easily understood? Have eighteen internationally known physicians contributed to the book? Have you considered whether this may not be a disadvantage? Come, my dear Watson, I fancy I hear a hansom outside, and more important matters await our attention. . . ."

Daniel B. Stone
Arch. Int. Med. March, 1960

Does the patient sleep? Karl M. Lippert, M. D. (Columbus, Ohio) (Tri-State M. J. 7: 8-11, Jan. 1960)

Simple observation of a patient will not determine whether he is asleep or in a coma. Coma is a form of deep sleep which cannot be reversed as a simple response to ordinary physical stimuli such as sound, touch, cold or heat. Any system whereby hypoxia in the brain cells is produced will bring on sleep. If hypoxia of the cells advances beyond an immediate reversible state, coma ensues and may continue to an irreversible state or death. The direct effect on brain tissue of hypoxia is a lowered pH and hydration of the protein colloid in the cellular matter. Although the increased hydration affects all tissues similarly, in the closed calvarium 5% increase (swelling) of the brain volume will produce coma and 8% will result in death. These figures become significant when it is pointed out that a slice of normal brain laid in a 1/10,000 normal lactic acid solution will increase its weight 200% in 24 hours (1/10,000 normal solution lactic acid is too weak to give usual sour taste to solution).

Some diseases which affect the brain through altered hydrophilic properties are diabetes, uremia, cardiac failure, chemical poisonings, light metal poisonings, certain drug excesses, and sequelae of anesthetic agents.

Treatment of this excessive brain edema requires the judicious use of electrolyte and carbohydrate solutions intravenously. Also, in cases of coma resulting from trauma to the brain, spinal fluid drainage and cranial decompression may be required.

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THE SURGICAL TREATMENT OF DISSECTING ANEURYSMS OF THE THORACIC AORTA

USING CONTROLLED EXTRACORPOREAL CIRCULATION

A CASE REPORT*

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The surgical treatment of dissecting aneurysms of the thoracic aorta proposes a tremendous challenge to the surgeon. The physiological and technical problems involved are multiple and the mortality rate is high. A correct diagnosis is paramount if the mortality rate is to be improved. While there has been improvement in the diagnostic criteria for dissecting aneurysm during the last decade, accuracy of diagnosis continues to fall short, according to post-mortem examinations.

In 1933 Shinnan reported a review of 317 cases in the world literature. Of these 317 cases, only 6 cases were diagnosed properly antemortem. During the next six years, of 82 additional cases, a correct diagnosis was made 26 times (Holland and Bailey). In the next four years, 153 cases were added to the literature with a correct antemortem diagnosis in 36 (Reich).

In general, there are two prime considerations in temporary occlusion of the thoracic aorta at the time of surgical correction of aneurysm: the effect of the increased vascular resistance upon the heart, and the ischemic effect upon the brain and spinal cord. Several methods have been utilized to prevent central

The methods utilized in the repair of dissecting aneurysm are discussed. An illustrative patient is presented in detail. The operative procedure used in the treatment of this patient is described by drawings.

nervous system damage during thoracic aortic resection. The metabolic requirements of the spinal cord or brain can be lessened by general body hypothermia. Most of the patients with dissecting aneurysm are in the older age groups where cooling and re-warming in itself creates a definite hazard. In addition, cardiac arrhythmias are also more likely to occur, and the length of time available to work with the occluded aorta is limited.

The other method of approach invokes various types of temporary intra-luminal and extra-luminal shunts designed to provide circulation to the distal arterial segments during the period of aortic occlusion. While these shunts have worked quite effectively in some cases, disadvantages are present which have justified the search for a better method. In 1957 Cooley³ introduced the use of the cardiopulmonary bypass in the treatment of aneurysms of the proximal aorta. At approximately the same time, Gerbode *et al*¹ used

* Supported by the John A. Hartford Foundation Fund.

extracorporeal circulation for the treatment of traumatic thoracic aneurysms. Both investigators found this method to be highly satisfactory in preventing neurologic, renal, and cardiac sequelae.

The following case report demonstrates the successful use of the bypass pump method:

W. F. A93589. This 50 year-old colored male was admitted to Roper Hospital on December 12, 1958 with a diagnosis of dissecting aortic aneurysm. He gave a history of intermittent abdominal pains during the previous two weeks. These pains had changed in location from the upper part of the abdomen to the left lower portion of the abdomen and radiated to the left flank and the lower back, becoming more frequent and severe. Three days before, the patient had become anorexic, nauseated, and had begun to vomit. Approximately one week prior to admission he had developed paralysis of the left leg and was admitted to a hospital for evaluation. At no time was a history of hemoptysis, melena or claudication given. The paralysis of his left leg cleared spontaneously, as did his nausea and vomiting. An x-ray film of the chest made prior to hospitalization showed the thoracic aorta to be dilated and tortuous.

The patient was found to be a well developed and nourished colored male in moderately acute distress. The blood pressure, pulse, and respiration were normal. The oral temperature was 101.6° F. The eyes were normal except for grade II arteriosclerotic retinal changes. Examination of the chest showed decreased breath sounds over the right hemithorax. There were coarse breath sounds, without dullness, over the left base. The heart had a normal sinus rhythm and no murmurs but was slightly enlarged to percussion. There was no neck vein distention. The abdomen was flat with vague fullness in the left lower quadrant but without definite pulsations. There was tenderness in the left lower quadrant and left flank with moderate rebound tenderness. Peristalsis was hypoactive. Examination of the extremities showed the left leg to be cool and pulseless. The right lower extremity was warm, and the pulses were good. The left radial pulse was diminished when compared with the right. Carotid pulsations were equal bilaterally. Neurological examination was normal except for hypoactive deep tendon reflexes on the left when compared with the right. A rectal examination was negative.

Laboratory data: The hemoglobin was 12 grams; the white blood count was 15,900 cu./mm. with a polymorpholeukocytosis. The urine was positive for albumin and sugar, but negative for acetone. Microscopically there were 6 to 8 pus cells but no red cells per high power field. A chest roentgenogram revealed elongation and tortuosity of the thoracic aorta with probable mild dilatation of the arch, but no involvement of the abdominal aorta. There was slight thickening of the pleura along the inferior left lateral chest wall.



Figure 1

This drawing illustrates the double lumen if the dissected aorta. The vent in the intima was not visualized but is usually located in this area statistically.

On December 11, 1958, under general endotracheal anesthesia, exploratory thoracotomy was performed in the standard postero-lateral approach through the fifth intercostal space. The right leg was exposed for isolation of the femoral artery. In the left pleural cavity there was a small amount of fibrino-serous fluid with early fibrinous adhesions between the left lung and the thoracic aorta. The entire thoracic aorta from the root of the aorta to the diaphragmatic aperture was approximately three times its normal size. The adventitial layer appeared erythematous and edematous, but there was no definite bluish discoloration discernable along the aorta.

The posterior parietal pleura was elevated from the aorta and the pericardium was opened parallel and posterior to the phrenic nerve exposing the left auricular appendage. The right common femoral artery was then isolated through a vertical incision below the inguinal ligament. A #22 Bardic catheter was inserted through a purse string suture into the right common femoral artery and clamped. Another #22 Bardic catheter was inserted within the confines of a purse string suture into the left auricle. Proximal and distal control of the thoracic aorta at a point near the end of the dissection was obtained.

The patient was given 200 mg. of heparin intravenously, and the previously placed Bardic catheters were connected by means of tygon tubing to the Sigmamotor pump. The pump was started, and a low flow rate was established. The thoracic aorta was then cross-clamped. The blood pressure in the arms immediately rose, and this rise was controlled by in-

creasing the speed and rate of flow in the Sigmamotor pump. When the blood pressure was maintained at the pre-operative level, the thoracic aorta was divided almost completely, leaving an area of wall medially measuring approximately 1.5 cm. Upon opening the aorta, a complete rent was noted in the medial layer extending over the entire circumference except for an area of approximately 2 cm. postero-laterally. (Fig. 1). There was no apparent clot in the medial layer.



Figure 2

A window is cut from the intimal layer and the remaining portion of the proximal double lumen is closed with sutures.

The distal double lumen was closed by means of continuous suture (Fig. 2). In the proximal portion of the aorta a window, 3 x 3 cm. in size, of dissected intima was removed. (Fig. 3). The full thickness aortic wall was then reapproximated, except for that portion overlying the window where the adventitia above was sutured to the entire wall below (Fig. 4). The clamps were removed; no unusual bleeding was noted. The left atrial—right femoral shunt was then discontinued and the catheters removed. Following the removal of the indwelling catheters, the patient was given 200 mg. of polybrene to counteract the effects of the heparin. The pericardium was closed loosely with interrupted sutures of 3-0 black silk. The thoracotomy wound was then repaired in the usual manner, leaving an indwelling catheter in the pleural for post-operative sealed drainage.

At the end of the procedure the left femoral and popliteal pulses were palpable and of good quality. The patient's post-operative course was uncomplicated. All of the peripheral pulses returned to normal, and the pre-operative pain and discomfort cleared. He

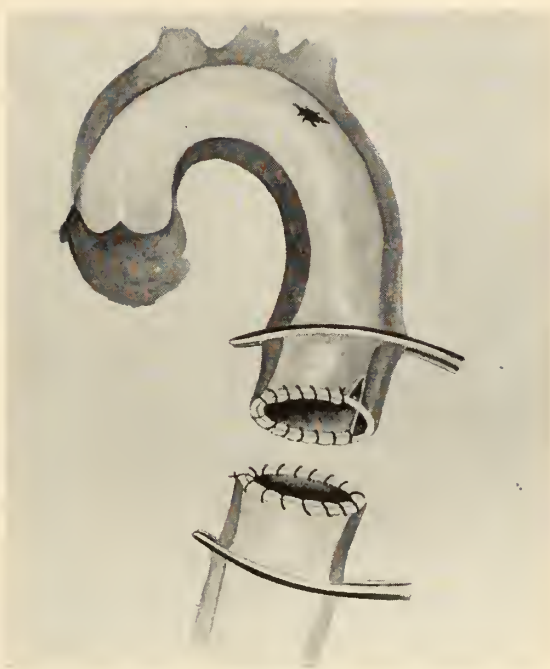


Figure 3

This diagram shows the closure of the layers of the distal aorta, thus making it possible to convert the abnormal aortic flow proximally into the normal channel distally.

was discharged on his 13th post-operative day. Recently in the Peripheral Vascular Clinic, he presented no subjective complaints and his peripheral pulses were normal.



Figure 4

The aortic division is reapproximated except for the window. The arrows depict the directional flow.

Discussion

At this time utilization of extracorporeal circulation is, by far, the most satisfactory method that has been proposed for the treatment of thoracic aortic aneurysms of all types. The method is new, and the technique has to be highly individualized. The procedure itself is not without hazard and requires meticulous attention to detail. The possibility of air embolism is omnipresent and its prevention requires constant monitoring of the system. The catheters which are placed in the auricle and the femoral artery must be pre-calibrated as to minimal and maximal flow rates that can be maintained at a given pump speed. If, dur-

ing bypass, the blood pressure of the arm is maintained at a pre-operative level, it is assumed that the apportionment of blood is adequate in the lower parts of the body as well as in the brachio-cephalic areas.

Summary

- (1) A brief discussion of the methods available for surgical treatment of dissecting aneurysms of the thoracic aorta is presented.
- (2) A case report of a dissecting aneurysm of the thoracic aorta, which was successfully treated using the extracorporeal pump to bypass the involved segment of the aorta, is described.

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DWARFISM

SOME CLINICAL ASPECTS

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Sponsored by N. I. H. Grant 436.

A 15 year old white boy was admitted to the Medical College Hospital for study of his dwarfism in February, 1960.

The patient's weight at birth was 6 lbs. 12 oz. He sat alone at 6 months, walked at one year, and began saying words by one year of age. All of his life he had been considerably smaller than children his own age, according to his mother. He had had no serious illness or injury. He was in the ninth grade at school and did fairly well in his studies. There was, however, considerable emotional lability and the patient was singularly uncooperative during his hospitalization. No medications had been given him at any time other than vitamin preparations. His appetite had always been poor and he was a very finicky eater, but there were no food pendants.

Both parents and his only sibling, a brother, were of normal size. A great-uncle was said to have been less than five feet tall and several aunts of undersize stature.

On physical examination the patient's height was 4'5" (53 inches), weight 78 lbs., blood pressure 104/60 mm. Hg., and pulse 88 per minute. The arm

span was 51 inches. He appeared well proportioned except for slight prominence of the forehead. There were numerous verrucae present over the skin of the trunk but otherwise the physical examination was normal. The genitalia were puberal with early pubic hair growth and normal size penis and testes. Neurological examination was normal except for rather marked hearing loss which was shown by audiograms to be a nerve conduction deafness involving both sides.

Hemograms were normal and estimation of platelets showed them to be adequate. Urine was negative except for the presence of 1+ albuminuria. Urea nitrogen was normal (15 mg./100 ml.) and a urine culture was negative. Likewise the fasting blood sugar and the total and fractional blood proteins were normal. BMR was reported as -2. Serum calcium was 11.4 mg./100 ml. and serum phosphorous 5.7 mg., both within the normal ranges for childhood. Serum cholesterol was 200 mg. Radio-active iodine uptake was 18% at 24 hours (in the low normal thyroid function range.)

An insulin tolerance test showed normal response.

Excretion of 17 keto-steroids was 2.63 mg. in a 24 hour urine specimen, a low normal level. A chest roentgenogram and multiple films of the skull were without abnormality. The bone age was judged to be normal and there was no evidence of epiphyseal dysgenesis.

The patient's diagnosis at discharge was "probable primordial dwarfism."

In the broadest sense, a dwarf is defined as an individual conspicuously smaller than others of his kind.¹ In establishing this diagnosis one should be mindful of the prognostic implications which may be far reaching, and of the necessarily important therapeutic considerations involved.

The term "dwarfism" embraces a large variety of diseases. Some 19 different types are enumerated in the medical dictionary.² Efforts have been made to simplify classification, and both Wilkins¹ and Shelton³ have devised less complex, more helpful classifications, based on *etiologic* factors rather than physical appearance or some even less reasonable criterion. Shelton's classification is as follows:

- I—Inherent or constitutional factors (as in primordial dwarfism and in normal, small statured persons)
- II—Congenital disturbances of the skeleton (as in achondroplasia, mongolism, and micromelic dwarfism)
- III—Anomalies of circulatory and urinary systems (as in congenital heart disease and kidney disease, renal rickets, etc.)
- IV—Disturbance of nutrition
 - A. Inadequate food, vitamin, and mineral intake (as in slow starvation, rickets, and other deficiency diseases)
 - B. Inadequate absorption of the building essentials from disturbance of the gastric, intestinal, and pancreatic enzymes. (as in hypochlorhydria, celiac disease, refractory rickets, intestinal nematodes)
 - C. Inadequate utilization or disposition of the essential elements from various metabolic and endocrine disorders (as in hypothyroidism, hypopituitarism, diabetes)
- V—Chronic infectious disorders (as in tuberculosis and leuc).

To this array, Wilkins adds a group which is quite significant clinically, characterized as "Delayed adolescence with retarded growth spurt." It is easily understood that some of these types will tend to overlap as dwarfism is seldom due to a single etiologic factor.

Fortunately for the clinician presented with a problem of delayed growth or dwarfism, many of the types included in this formidable differential diagnosis can be quickly ruled out. For example, the bone diseases comprise a large element of the dwarf population; indeed, achondroplasia is said to be the commonest cause of true dwarfism.⁴ These unfortunate patients are easily recognized by their grotesque facies and bodies as having chondrodystrophies, dysostoses, or degenerate bone disease. Likewise, the stunted, usually cyanotic victim of congenital heart disease can be often distinguished without exhaustive study. The growth disorders due to chronic diseases of the liver, kidneys, or gastrointestinal tract may be diagnosed by careful systemic workup, especially since the advent of percutaneous methods of biopsy of the liver and kidney.

According to Wilkins,¹ it is only after bone, nutritional and other diseases have been ruled out that dwarfism due to endocrine or genetic disturbance should be considered.

Upon being confronted with the problem of a physical retarded child or adult, one often recognizes no stigmata indicative of an obvious cause. Assuming the bone, nutritional and other diseases have been ruled out, we may turn to four entities which comprise most "endocrine and genetic" disturbances:

- 1) Hypothyroidism ("sporadic" or "childhood myxedema")
- 2) Hypophyseal infantilism (panhypopituitarism)
- 3) Primordial dwarfism
- 4) Constitutional delay in growth and adolescent development

Before discussing these causes, however, it is worthwhile to consider briefly a protocol for evaluation of such a patient.

An adequate history and physical examination is, of course, paramount. Such questions as birth weight, dietary habits, development, appearance of secondary sex characteristics, and mental acuity should be asked. Frequently the family album may be of help as a pictorial record of development. Likewise, the family history of stature and growth of the parents, siblings, and other relatives should be reviewed. A history of serious illness or injury

could be the key to the diagnosis, (c. g., encephalitis, subdural hematoma).

Physical examination should include particular attention to features which suggest infantilism, such as the facies, size of the head and trunk, and length of the extremities. Subtle changes in the skin, hair texture, and distribution, and the musculature are often important. Development of the breasts, genitalia, and other secondary sex characteristics should be noted. Evaluation of the mental faculties may be of help. A careful neurologic examination may be very revealing.

Laboratory evaluation of endocrinologic and genetic make-up are directed at testing pituitary and other endocrine gland parameters. Thyroid studies such as the protein bound iodine, radio-active iodine up-take, and basal metabolic rate are useful, and adrenal function may be measured by the determination of 17-ketosteroid and 17-hydroxysteroid excretion or by the water loading test, which is regarded as the best test of the pituitary-adrenal axis in children.⁵ The insulin tolerance test is also a valuable adjunct to study.

In addition, gonadotrophin levels plus 17-ketosteroids will give information about gonadal function after puberty. Often helpful also is the glucose tolerance test as well as the alkaline phosphatase which reflects skeletal activity. Frequently the patient's sex must be determined cytologically as in cases of dwarfism due to ovarian agenesis where 80% of the apparently female dwarfs are genetically actually males. In addition, roentgenograms will establish bone age and disclose any abnormalities of development. Further films may be indicated as, for example, skull films to evaluate the sella turcica, or to look for intracranial calcifications or erosions.

HYPOTHYROIDISM

This category of dwarfs comprises the most common of endocrinologic disorders of childhood. Furthermore, they are the ones most amenable to treatment.⁶ About four-fifths of children with hypothyroidism have had it since birth.¹ Though not all of these patients look alike, the typical coarse skin and hair, infantile skeletal proportions, usually retarded mental development are consistent features in untreated cases. Additionally there is usually

weakness, constipation, anemia of moderate degree, and laboratory tests show elevated cholesterol and depressed alkaline phosphatase levels.

Diagnostic tools which are of value include x-ray, which is the most important aid to early diagnosis. Here is seen a delay in ossification with a type of "epiphyseal dysgenesis" where calcification of the epiphyseal centers occurs in a scattered, irregular fashion.⁸

Evaluation of protein-bound iodine and radio-active iodine uptake are helpful, falling of course in the hypothyroid ranges, unless some form of drug therapy has been recently administered. A low basal metabolic rate, though, should not be construed as evidence of hypothyroidism in the absence of other confirmatory evidence.

There are two situations in which the diagnosis of hypothyroidism may be more difficult. One is in the case of the partial or sporadically treated dwarf, where some response may have been shown, but growth is still retarded. Here diagnosis may be further obscured by erroneous laboratory results. A second situation is the one in which the thyroid defect is not one of absence or atrophy of the gland, but rather in synthesis of thyroid hormone. These cases have been reported⁹ as showing high I^{131} uptakes, but production of an iodinated protein which is not utilizable by the body.

Therapy is substitutional, the dosage of thyroid increasing with age. The earlier therapy is begun, the better is the patient's chance of obtaining normal physical growth and mental development. It is important to remember, however, that the adult myxedema patient should be started on extremely low dosages which are gradually over a period of weeks increased to the normal maintenance level.

HYPOPHYSEAL INFANTILISM

According to Lisser and Escamilla¹⁰ this condition is not rare though it comprised the smallest group in the 442 cases reported by Martin and Wilkins in 1958.⁵ Etiology of hypophyseal dwarfism is said to be frequently a tumor or other destructive lesion of the gland, but in nearly two-thirds of Martin and Wilkins' 30 patients the disease was due to idiopathic hypofunction of the pituitary gland. This type of dwarf is normal at birth and per-

haps through the early years of growth but his appearance becomes marked by infantile facies, absent secondary sex development (an occasional one matures), and short stature or actual dwarfism. Emotional instability is a frequent finding but the intellect is usually found to be normal. The patient is underweight rather than obese, and the skin becomes strikingly thin and wrinkled.

Diagnosis rests on demonstration of hypofunction in the "target organs" of the pituitary—adrenal, thyroid, and gonads. It is therefore exceedingly difficult to make a definitive diagnosis in childhood, since many adrenal and gonadal functions are normally absent until puberty. The demonstration of adrenal and thyroid hypofunction in a dwarfed child should suggest this disease⁵ but most authorities defer diagnosis until an age where sexual infantilism appears permanent.

At a post-pubertal age, these dwarfs often show diminished function of all "target glands." The protein-bound iodine and radioactive iodine uptake may be low, though overt features of hypothyroidism are commonly absent. Adrenal tests also indicate hypofunction, with low 17-ketosteroids and 17-hydroxysteroid excretion and failure to initiate diuresis after water-loading. Classical Addisonian symptoms are rare, though some of the dwarfs have occasional syncopal episodes from hypoglycemia. Gonadotrophin levels are low. In addition, bone development is disturbed with ossification of epiphyseal centers occurring late with frequent failure of these epiphyses to unite.

Again here, treatment is substitutional. There are recent accounts^{11, 12} of use of monkey and human growth hormone in treatment, but experience is limited as yet with these preparations. Use of bovine growth hormone has been uniformly unsuccessful. Both thyroid and adrenal hormones may be supplied in indicated dosages. More critical is the decision to use androgens or estrogens at the time of puberty in order to increase height and to induce secondary sex characteristics.

PRIMORDIAL DWARFISM

This type of dwarf is the classical "adult in miniature." Various congenital anomalies are a frequent accompaniment,⁶ but development

in general pursues normal lines, scaled down considerably. Bone age is normal and the dwarf usually appears to be his chronological age.

Primordial dwarfs comprise about 25% of the group in Martin and Wilkins' study. The defect is probably mediated not through a specific endocrine lack but through a genetically determined diminished capacity for tissue growth.¹ Such dwarfism may occur sporadically in normal families and often these individuals procreate children who are usually of normal size.

CONSTITUTIONAL DELAY IN GROWTH & ADOLESCENT DEVELOPMENT

This group makes up the bulk of most reported series of retarded growth. Characteristically, the person is the "runt" who lags 2 to 4 years behind his contemporaries. He usually comes to the attention of the clinician because his parents fear some form of true dwarfism. Though differentiation from primordial or other forms of dwarfism may be difficult, ultimately this type will achieve sexual maturity and a reasonable semblance of, if not normal, adult size. One must remember that there are wide variations in patterns of development, and puberty may begin any time between ages 9 and 17 for normal children.

The predominant injury caused by delayed growth and adolescence is probably to the child's psyche, and though conservatism in treatment is usually urged, sometimes psychological maladjustment may be adequate reason to initiate therapy. Here sex hormones are used to hasten puberty, but it is wise to remember that these hormones speed epiphyseal closure as well as encourage bone growth, and an ultimate loss of height can result.

CONCLUSIONS

A case of primordial dwarfism is presented.

Dwarfism is best understood by considering etiologic factors. Fortunately for the clinician, many forms of dwarfism can be fairly readily recognized, and it is only after bone disease, nutritional disturbances, and chronic systemic diseases have been ruled out that one should pursue an endocrine or genetic cause. The predominant types of endocrine and genetic

causes are discussed briefly, with a comment on the value of wisely performed history

taking, physical examination, and laboratory studies.

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MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

Electrical Alternans

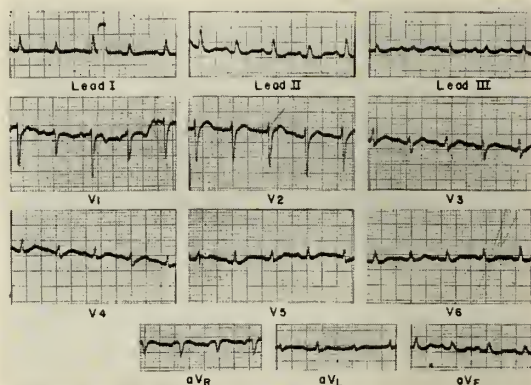
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Case Record—The tracing below was recorded on a 52-year-old Negro dying of malignancy. Previously she had received radiation treatment for carcinoma of the cervix. At the time this tracing was made her chest roentgenogram showed massive diffuse cardiac enlargement with congestion and edema, obscuring any evidences of pulmonary or cardiac metastases. There was no history of any primary cardiac disease and a chest roentgenogram two years previously was normal in respect to both the heart and lung fields.

An autopsy was not obtained.

Electrocardiogram—The rhythm is a sinus tachycardia which is entirely regular at a rate slightly more than 120. Voltage of all complexes is moderately low throughout (QRS 5 mm. or less in all the limb leads) in spite of gross cardiac enlargement.

Careful inspection of the tracing shows that there is a regular alternation of two distinct types of QRS complexes, the difference between them being mainly one of amplitude. The alternation is more evident in some leads (V₁, aVR) than in others but is undoubtedly present throughout. Supraventricular conduction appears to be normal for all beats and the T waves are not appreciably altered by the QRS alternation.



Discussion—Electrical alternans is a conduction disorder in which there is a regular alternation of QRS complexes of different amplitude and configuration. Often there is an associated difference in their T waves and at times all waves of the cycle may be involved. It is distinguished from pulsus alternans which is an alternation in mechanical function. While both electrical and mechanical alternation may exist concurrently the two are separate and independent phenomena and the presence of one does not imply presence of the other.

Little is known of the mechanism of electrical alternation. Electrocardiographically it appears to derive from two different pathways of intraventricular conduction. These may differ very markedly or, as in this case, very little. Understandably some leads

would reflect such a small difference more distinctly than others. A postulated anatomic alternation of cardiac position with successive beats, perhaps facilitated by fluid in the pericardium, seems an unlikely explanation since the contrast in complexes in some cases is far greater than could be attributed to an axis shift and moreover there is usually no associated variation in the atrial complexes. The most widely accepted view at present is that electrical alternation is due to a prolongation of the refractory period of some area of the myocardium, either in the conduction system or in the muscle itself, so that following a previous activation a subsequent impulse finds some region of the myocardium still refractory.¹ Thus on alternate beats that localized area is bypassed or incompletely depolarized. It would then follow that electrical alternation would be more frequently observed with faster rates, which is generally true. The localized impairment of conduction could be caused by ischemia, infection, neoplasm or any other organic

lesion of the myocardium or its conduction pathways. However electrical alternans has been reported in single ventricular fibers using microelectrode techniques.² One wonders about a possible relationship between electrical alternans and intermittent bundle branch block or anomalous atrioventricular conduction.

Electrical alternation has also been described in normal hearts, in digitalis toxicity and as an aftermath in prolonged tachycardias. It is a curious, non-specific finding about which much remains to be learned.

REFERENCES

1. Schamroth, L., Segal, F., and Rabinowitz, D.: Electrical alternans with unusual features. *Am. Heart J.* 58:900-904, 1959.
 2. Kleinfeld, M., Sten, E., and Magin, J.: Electrical alternans in single ventricular fibers of frog heart. *Am. J. Physiol.* 187:139-142, 1956.
- Acknowledgement—My thanks to Dr. Gabriel P. Joseph of Myrtle Beach, S. C. for submitting this interesting case.

The coincidence of patent ductus arteriosus and rheumatic heart disease, with a comment on the "post-commissurotomy syndrome." John A. Boone and Robert M. Rosemond (Charleston) (*Am. J. Med.* 28: 247-251, Feb. 1960)

The frequent occurrence of rheumatic heart disease in patients with hearts showing interatrial septal defects is now fairly well known. It is less well known that autopsy evidence of its association with many other congenital heart defects has been reported in several papers.

Among a total of 73 patients operated upon for patent ductus arteriosus at the Medical College of South Carolina heart clinic, 36 had adequate observation over a period of two to seven years following operation. Of the 36 patients, clinical evidence of rheumatic fever or a progressive valvular disease has developed in six. The study suggests a more frequent association between patent ductus arteriosus and rheumatic heart disease than has been previously suspected, and in some cases operation may have either precipitated or reactivated rheumatic fever.

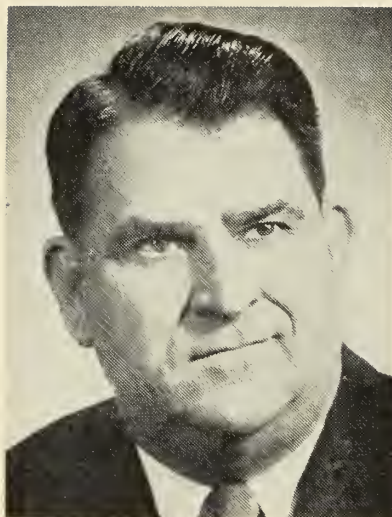
It is believed that these findings support the concept that the so-called "post-commissurotomy syndrome" following operations for mitral stenosis is a reactivation of rheumatic fever, rather than a traumatic pericarditis, as has been suggested because of its occurrence following operations on congenital heart lesions in patients presumably free of rheumatic infection.

The suggestion is made that long term observation following operation for congenital heart defects should be particularly alert to the possibility of rheumatic heart disease, and that perhaps regular antibiotic prophylaxis should be instituted.

John A. Boone, M. D.

Some observations of the interpretation of renal function tests in renal disease. Cheves McC. Smythe, M. D. (Charleston) *Tri-State Medical Journal*, 8 20, Mar. 1960.

Careful scrutiny of urinary specific gravity, the degree of proteinuria, and the urinary sediment can give enough information with which to make an accurate diagnosis in the majority of cases. A fixed urinary specific gravity in the presence of tubular renal disease does not have the prognostic import of this finding in glomerulonephritis. Heavy proteinuria is characteristic of glomerular disease. A diagnosis of postural proteinuria should not be firmly made until one has determined that there are not increases in red cells and casts in the urine in response to exercise. The degree of proteinuria in no way reflects the functional status of the kidney. Gram stain of the urinary sediment is a useful technique for the detection of bacteriuria. A 15 min. PSP excretion of over 25% indicates a glomerular filtration rate of at least 60% of normal. Lower PSP excretion does not prove that renal function is poor, but indicates need for careful studies of renal functional status.



President's Page

SOCIAL SECURITY FOR PHYSICIANS

On Thursday, June 9, 1960, the House of Representatives passed an omnibus Social Security Bill, amending the Social Security Act in four areas: (1) medical care for the "medically indigent" aged; (2) incentive program to the states for improvement of their public assistance program; (3) liberalization of the requirements for disability benefits; and (4) *compulsory coverage of physicians under the Social Security Act*.

In this letter, I propose only to discuss Number 4.

The inclusion of physicians under the Social Security law has been a controversial question within the House of Delegates of the American Medical Association for

many years. Compulsory coverage of physicians under this act has been regularly reviewed by the American Medical Association's House of Delegates at various sessions, including the last one held at Miami Beach this year.

In 1958 the American Medical Association requested each individual state to poll its membership, concerning their inclusion under the Social Security Act.

The South Carolina Medical Association appointed a committee to study this problem and, at the 1959 meeting in Columbia, the House of Delegates accepted this committee's report a part of which read as follows: "The Committee on the Study of Social Security for Doctors recommends that Social Security be disapproved at this time. The reasons are listed as follows: (1) Under the present system, payments for Social Security will be borne by future generations, and on this basis it is morally wrong. (2) Social Security is financially unsound. There is no contract. There is no relationship between the amount of money paid in to what is to be received. (3) If Social Security is accepted by the physicians, the profession will be liable to socialized medicine in its most vicious form." In this report the Committee also recommended that the membership of the South Carolina Medical Association be polled by mail concerning this question.

This poll was remarkable in several respects. First of all perhaps is the interest shown by the high percentage of replies received. Out of a total of 1400 cards mailed out — 989 were returned.

Two questions were asked:

No. 1—Do you think physicians should be included under Social Security?

No. 2—Do you think physicians should be permitted to participate on a voluntary basis?

The physician answering the questions was asked to state his age, so that some determination of the opinions in the different age groups could be ascertained.

The results showed that in the ages 25 to 39 — 139 answered "yes" to question No. 1, while 194 answered "no". In the age group 40 to 49 — 143 answered "yes" and 133 answered "no". In the 50 to 55 age group — 25 answered "yes" and 45 answered "no". Of those over 55 — 128 answered "yes" and 61 answered "no". Where ages were not given—4 answered "yes" and 6 answered "no", making the final tabulation extremely close, with a total of 429 answering "yes" and 439 answering "no".

In answer to Question No. 2, the answers were not so close. 780 answered "yes", and 200 answered "no". This was broken down in the 25 to 39 age group — 286 "yes" and 88 "no", 40 to 49 age group — 238 "yes", 62 "no". 50 to 55 age group — 69 "yes" and 19 "no", over 55 — 178 "yes", 28 "no"; and the group of ages not given — 9 "yes" and 3 "no". The discrepancy in the totals of these two questions is accounted for by the fact that on some cards, both questions were not answered.

These tabulations seem to indicate that South Carolina stands just about where the other states in the Union stand on the Social Security question. While a few more physicians are against *compulsory* inclusion in the OASDI than favor it, a much larger majority is in favor

of *voluntary* inclusion under OASDI. This is essentially the stand which has been called to the attention of Congress as the official position of the AMA, as will be seen in a letter later on in this discussion.

Some were already covered under Social Security; for example, employees of the State and County Boards of Health, etc.; certain employees of the South Carolina Medical Association, Editors, etc., whose small remuneration has been taxed by this law since 1938; physicians who are covered because of an avocation; that is, executive positions in commercial corporations, etc.; physicians who served as Interns or Resident in a hospital where employees were under Social Security; some were on Social Security by having worked in eligible jobs before they ever studied medicine.

Other physicians who wanted to be included under Social Security had various reasons: Some felt that it will help them in their retirement plans. Many felt that since they contributed to the fund by being taxed for their employees, they might as well get something back as well as the other person. Some felt that if physicians were included under Social Security that their position in opposing amendments to extend Social Security Benefits would carry more weight since they would be criticizing a system of which they were a part, and not just being against something from which they have always stood aloof.

The reasons by those opposed can roughly be divided into two major areas: *philosophic* and *economic*.

The philosophic arguments are based on the theory, history and long-range prospects for social insurance systems. Social insurance schemes in foreign countries have gone from retirement payments-to survivorship payments-to temporary cash sick benefits, and finally — to national compulsory health insurance. The Social Security system in this country has followed the same pattern of expansion. It has moved farther and farther away from its original purpose of providing financial protection for aged citizens and has moved closer and closer toward the "cradle to the grave" concept.

Although the evolution of a social insurance program into a comprehensive welfare program, including socialized medicine, may take years, the experience of other foreign countries shows that this development is common. In view of these facts, it has been deemed unwise to request that Congress include physicians in a system which has traditionally been the vehicle through which medicine has become socialized.

The economic dangers of becoming part of the Social Security system are even more apparent. First, OASDI is not "insurance". The individual citizen has no legally enforceable right to obtain the benefits that he expects to receive. Congress has specifically reserved to itself the right to alter, amend, or repeal any provision of the program. The physician has no way of knowing what he or his family will receive in the way of benefits, and in addition he has no way of knowing the amount of tax that he may be required to pay for these unknown benefits.

In 1954 each Social Security beneficiary was receiving an average of \$30.00 in benefits for each 50 cents in taxes. This ratio has undoubtedly increased since the extension of benefits in 1956 and 1958. For many years income paid into the fund exceeded benefits paid out. However, benefit payments have now caught up and exceeded income so much so that it is estimated that this year benefit payments will exceed income by over a billion dollars. These figures demonstrate the instability of the program as a self-financing system. In addition, the total unfunded debt of the OASDI program is estimated at \$325 billion. When the maximum number of beneficiaries become eligible either the Social Security taxes will have to be increased tremendously or the benefits will have to be materially restricted.

The pending bill, now known as the Mills Bill, would bring physicians under Social Security coverage for "taxable years ending on or after December 31, 1960". Selfemployed physicians would therefore be liable to a tax of 4½% on their 1960 income up to \$4,800. This title also extends coverage to interns and residents in federal hospitals and interns in private, non-tax-exempt hospitals (interns in tax-exempt hospitals are presently covered if the hospital has filed a certificate electing coverages for its employees and or the intern makes an election of coverage). Interns and residents would pay the social security tax of 3% on income up to \$4,800 after January 1, 1961. This also would provide that municipal and county hospitals would be considered as separate retirement systems, thus allowing them to make an election for social security coverages for their employees, notwithstanding the fact that the city or county has rejected coverage for its employees.

The following letter has been written by AMA President-Elect, Dr. Leonard Larson, to

Honorable Harry F. Byrd, Chairman of the Senate Finance Committee, United States Senate, Washington, D. C., concerning our position on Social Security in the American Medical Association:

Dear Senator Byrd:

In a separate statement submitted today, I presented the views of the American Medical Association with respect to Title VI of H. R. 12580, 86th Congress, now pending before your Committee. This measure also provides for the compulsory inclusion of physicians under Title II of the Social Security Act. This letter is written for the purpose of restating the position of the American Medical Association in this regard.

As far back as 1949, the House of Delegates of the AMA went on record as opposing the inclusion of physicians under Social Security on a compulsory basis. This position has been restated by our House of Delegates regularly once or twice a year since 1953. This policy statement was amended by our Board of Trustees in 1954 to remove any objection to the voluntary inclusion of physicians under the Act.

Following the clinical meeting of the Association in December, 1955, many of the state medical societies, at the suggestion of the House of Delegates, conducted a poll of their members on the question of compulsory inclusion of physicians under Social Security. Although uniform questions were not asked in these state polls, it can be concluded from the results that a majority of the profession is still opposed to compulsory coverage. It is true that several state medical societies have endorsed coverage of physicians. Our House of Delegates, however, of 200 physicians representing every state, has overwhelmingly rejected proposals for coverage. The most recent action of this body in opposition to compulsory coverage for physicians was taken at the Association's Annual Meeting held in Miami Beach earlier this month.

OASDI does not fit the economic pattern of the practicing physician. Self-employed doctors rarely retire at age 64. Therefore, the compulsory tax which would be imposed upon them, were they covered under the Social Security system, would be unjust and unreasonable. Physicians who are able to work prefer to keep right on practicing medicine. A survey of this point shows that over 85% of the doctors between the ages of 65 and 72 are in active practice. Over 50% of the physicians who retire do so after the age of 74. Thus, if forced under this program, the typical physician would be required to pay social security taxes until age 72 before he would receive benefits.

Finally, and perhaps most important, physicians have seen social insurance programs in other nations used as a vehicle for the establishment of socialized medicine. They have fought against the Wagner-Murray-Dingell bills of 1949 and the Forand bills of today. They know that the OASDI system constitutes the principal avenue by which socialized medicine advocates hope to achieve their goal. Naturally, they are highly sensitive to their inclusion in a system which may eventually be used to abridge their freedom as a profession.

For the aforementioned reasons, the medical profession is opposed to the compulsory coverage of physicians under Title II of the Social Security Act. If you or any of the members of your Committee desire further information concerning our position, I would be happy to supply it.

Sincerely yours,
(Signed)
Leonard Larson, M. D.

By the time you read this letter, Congress may have already made a decision on this Bill; however, since Congress will not readjourn until August, and hearings before the Senate Finance Committee will be held before any action is taken, it was felt that this discussion was particularly timely at the present. Whatever your personal feelings are in this regard should be addressed to Senators Thurmond and Johnston.

Joseph P. Cain, Jr.
President

Editorials

THE RELUCTANT DIME

Not very long ago the National Foundation for Infantile Paralysis announced that its program was to be changed, and that activities in the field of arthritis and some few congenital defects were to be initiated. The implication to the public was that the problem of poliomyelitis had been solved and that it was no longer necessary to expend the efforts previously devoted to it. At the time many people felt that this was a serious mistake, that polio was by no means conquered and that the Foundation was being much too premature in undertaking new efforts before its original interest had been served. Curtailing its name, the National Foundation proceeded to make certain changes in its policy and set up a new effort which would presumably appeal to the public as much as has had the old one.

The result of this change is that the National Foundation has fallen far below its figure estimated as necessary in its fund raising, and has accumulated less than half the amount which it had set as the goal. Apparently this has not been sufficient to carry out the proposed program, even insofar as it included poliomyelitis, as according to a recent newspaper report the Foundation is now two million dollars in debt for the care of polio patients alone. The drop in the amount has been attributed to the feeling by the public that the development of the Salk vaccine had, in effect, solved the problem of the disease, but nothing could have fostered this feeling better than the change which the Foundation itself made in its publicity and its policy.

At the recent meeting of the A.M.A. there was an expression of feeling that the National Foundation had been quite premature in its change, and there was definite suggestion that the Foundation resume more actively its efforts against polio. Suggestions were also made by the A.M.A. as to how local policy might be regulated for the various medical organizations which have in the past participated in

the drive for the March of Dimes, and have given their services and advice freely to the local chapters of the Foundation.

It might be wise for the National Foundation to re-attach the discarded tail-end of its title and to concentrate again on that problem for which it was developed and supported. If it could concern itself only with the one still important polio and confine its expenditures to one channel, at the same time denying itself the old privilege of handing out large sums of money for projects which were very remotely related to its primary interest, it seems likely that it might resume its former position. Certainly the changes which it made appear now to be grievously in error.

STATE MEDICINE IN SASKATCHEWAN

The electorate of Saskatchewan has voted for a measure which practically puts the doctor's bill out of circulation. Despite valiant efforts of the doctors of this Canadian province, including a contribution of one hundred dollars from each for purposes of counter-propaganda, the measure was passed with a substantial margin and the province will now operate a full fledged medical care program, apparently the first of its kind on this continent.

The system allows free choice of physicians, but there is no way to tell how much provincial regulation will be established and what the general effect on the morale and efficiency of the profession may be. Under the scheme a single person pays from \$17.50 to \$20.00 a year, the head of a family pays \$35.00 to \$45.00 a year, and taxes raised in this manner are supposed to take care of 40% of the cost of operation for the whole program. The other 60% will come from general tax funds.

Except in the province of Quebec, all Canadian provinces have had in operation a hospital plan whose cost is shared by the Federal and Provincial governments. Undoubtedly we will want to continue our policy

of "Hands Across the Sea", but some question might be raised as to whether we will enjoy Socialism Across the Border.

GOATY BRINKLEY

Subjects for biography are endless, and it appears that popular taste runs to those books which expound the nefarious careers of crooks and scoundrels rather than those of the more respectable members of the population. A new book which has just appeared concerning the life of John Romulus Brinkley is a striking example.

Brinkley has left us not too recently after a surprising career which indicated his genius for quackery, and the naive gullibility of the public. Coming from up in the Great Smoky Mountains, he managed to secure medical credentials which kept him within the law and for years he reaped a rich harvest from the thousands of aging males who aspired to a restoration of virility. Goat glands were the magic items which were to accomplish the goal, and over a period of twenty-five years Brinkley performed sixteen thousand operations at \$750 apiece for an eager and optimistic clientele. The A.M.A. did all that it could for years and finally Brinkley was toppled from his position as champion of the quacks.

A little way over the North Carolina line from us is a large marker with a plaque extolling the kindness and virtues of a relative who was kind to Brinkley in his childhood. It might be wondered whether the old lady might not have done more service to humanity if she had lessened her kindness to Brinkley and drowned the developing genius of charlatanism in the nearby creek.

RHEUMATIC FEVER AND THE STEROIDS

The value of the steroids in suppressing inflammatory reaction in the early stages of rheumatic fever is pretty generally accepted, and indeed it is thought that in congestive heart failure they may be life saving. There has been less agreement about the efficacy of the steroids in prevention of residual heart disease, and there has also been some questioning as to whether the effect of the

steroids even in the early phases was much more dependable than the use of salicylates to accomplish the same reduction in inflammatory activity.

A recent article concerns itself entirely with the question of the comparative values of steroids, specifically prednisone, and of acetylsalicylic acid in their roles as preventives of late residual heart damage. A study described in the paper was carried out very carefully, cases were selected with much discernment, and while the number involved is not very large, this might be considered a rather exact indication of the relative value of the two types of drugs.

The patients selected were in their first attack and were all treated early. The severity of the clinical picture and the duration of symptoms were both about equal in the group selected for division into the two categories of treatment. It was found that there was no real difference in the results as they were judged by the late picture and the presence of residues of the infection. In both groups, in the milder cases, complete recovery was the rule. Similarly, in severe cases, neither aspirin nor prednisone seemed to give any help toward prevention of residual damage, even though the drugs were given for as long as twelve weeks.

It may be emphasized that this report does not detract from the value of either drug in the acute stage of rheumatic fever, but only points to the finding that there was no demonstrable difference in the effects as far as the late picture is concerned.

New England J. Med. 262:896 (May 5, 1960)

BENEVOLENCE FUND

At the annual meeting of the Association the following report was adopted:

"The report of the Committee on benevolence. This committee recommends that the plan be adopted and put into effect. It further recommends that the plan be submitted in writing to each member of the Association. It further recommends that \$20,000 be appropriated (or what portion of this amount Council deems advisable) as an initial allotment; it further recommends that the present committee be elected to serve as the original committee on the basis of the plans as set forth in the original proposal. This committee so moves." This was passed.

Suggested Plan for Operation of Benevolence Fund

"The committee on benevolence appointed by the president of the South Carolina Medical Association January 2, 1960, respectfully submits to Council the following recommendations:

"1) The South Carolina Medical Association shall establish a benevolence fund,

"2) The purpose of this fund is to render pecuniary assistance to disabled or indigent physicians and to needy widows and children of deceased or disabled indigent physicians.

"3) This fund shall be created by an initial allotment of \$10,000 (or so much as deemed wise by council); from established funds of the Association; from voluntary assessment of members; from contributions; and from such other sources as may be interested (Woman's Auxiliary, County societies, Etc.).

"4) The fund shall be administered by a Board of Directors of the Benevolence Fund. This board shall consist of three members to be elected by the Association, one member for three years, one member for two years, one member for one year, term of office not to exceed three terms, and that vacancy may be filled by the Chairman of Council. The board shall elect its own chairman and secretary. The president, the treasurer, and the chairman of Council shall be ex-officio members.

"5) The directors shall be responsible for the administration of all monies entrusted to their care. It shall be their goal to establish a Permanent Fund from which only the interest may be used, it being understood that in the beginning this may not be at first possible.

"6) The board of directors shall have power to make rules and regulations to enable it to determine who shall be entitled to assistance or relief, so that it will be able to carry out the purpose for which the benevolence fund is established. The directors shall have exclusive control in designating beneficiaries and shall determine the sum to appropriate for each. The names of the beneficiaries for reason of delicacy shall not be published and shall be known only to the directors and ex-officio officers.

"7) The treasurer of the association shall be custodian of all benevolent funds and shall keep them entirely separate from all other association accounts. He shall assist and advise with the directors on all matters concerning investments for the permanent fund and carry out their wishes in these matters. He shall pay out funds from this account only on certification of the directors.

"8) The directors of the benevolence fund shall report to Council prior to the annual meeting of the house of delegates and at such times during the year as may be deemed necessary by the chairman."

Committee

W. Atmar Smith, M. D.

O. B. Mayer, M. D.

Thomas G. Goldsmith, M. D.

A Letter to the Directors of The Benevolence Fund South Carolina Medical Association

This letter is to acquaint you with my views concerning the establishment and administration of the Benevolence Fund.

1) This Fund should be under complete control of a Board of Directors with only such safeguards as proposed by the original resolutions adopted by the House of Delegates.

2) It should be created by an outright transfer of monies by Council, from present holdings of the Association to the Benevolence Fund.

3) The Fund could be augmented annually by a voluntary contribution of each member of the State Association. Statements of indebtedness sent to members annually might include a line "contribution to Benevolence Fund," no amount stated. It should be emphasized that this is to be purely a voluntary gift and not an assessment. No duress should be used.

4) The Fund might also be augmented by contributions from the Woman's Auxiliary of the State Association and from various chapters throughout the State. Laymen should not be solicited for contributions to the Fund. However, should any desire to contribute it will be accepted as an act of appreciation for professional service of some doctor or group of doctors. It is believed that this is a doctors problem and should be solved by doctors themselves.

5) It is believed that the Directors should seek out those in need and distress financially and not wait to be sought. Applications for assistance might readily be made by a colleague, a friend, a welfare worker conversant with the financial difficulties of the proposed beneficiary.

6) In rendering financial assistance attempts should be made to make the beneficiary feel that he is not an object of charity but rather that he is furnishing his medical colleagues an opportunity to render a worthwhile service. On the other hand funds should be reserved for those in need and not permitted to be exploited by cheats and unworthy persons.

7) A brief set of rules should be adopted by the Directors for their guidance.

W. Atmar Smith, M. D.

Chairman of The Board of Directors
of the Benevolence Fund of the South
Carolina Medical Association.

The Directors elected by the House of Delegates are as follows:

W. Atmar Smith, M. D., Charleston, S. C., 3 years

O. B. Mayer, Columbia, S. C., 2 years

Thomas G. Goldsmith, Greenville, S. C., 1 year.

Contributions to Fund

"Survivors"—Class of 1910 of Medical College of South Carolina	\$ 50.00
Temporary Allotment by South Carolina Medi- cal Association	\$500.00

Beneficiaries Two Physicians

**SOUTH CAROLINA MEDICAL
ASSOCIATION COMMITTEES, 1960-61**

1. *Committee on Scientific Program*
Dr. R. Cathcart Smith, Chairman—903 Bell Street, Conway
Dr. John D. Gilland—905 Bell Street, Conway
Dr. Walter R. Mead—Florence
Dr. Robert Wilson—165 Rutledge Avenue, Charleston (Ex-officio)
Dr. Joseph P. Cain, Jr.—Mullins (Ex-officio)
2. *Committee on Public Health*
Dr. W. Wyman King, Chairman—Batesburg
Dr. James B. Berry, Jr.—Marion
Dr. Douglas Jennings, Jr.—Bennettsville
Dr. Robert L. Sanders—1415 Barnwell Street, Columbia
Dr. Robert S. Solomon—Moncks Corner
3. *Memorial Committee*
Dr. M. R. Mobley, Chairman—Florence
Dr. Harold S. Gilmore—Nichols
Dr. Hugh P. Smith—Greenville
4. *Committee on Maternal Health*
Dr. Edward J. Dennis, Chairman—55 Doughty St., Charleston
Dr. A. Richard Johnston—St. George
Dr. Sol Neidich—1112 Craven Street, Beaufort
Dr. Swift C. Black—Dillon
Dr. James S. Garner, Jr.—Mullins
Dr. Charles R. May—Bennettsville
Dr. Robert M. Dacus, Jr.—200 E. North Street, Greenville
5. *Committee on Cancer*
Dr. William C. Cantey, Chairman—1840 Hampton St., Columbia (1963)
Dr. Leland J. Brannon—1726 Hampton St., Columbia (1962)
Dr. Edward S. Cardwell, Jr.—Columbia Hospital, Columbia (1962)
Dr. James R. Young—124 E. Earle Street, Anderson (1963)
Dr. Alton G. Brown—Clinic Bldg., Rock Hill (1961)
Dr. Jennings K. Owens—Bennettsville (1963)
Dr. Rufus K. Nimmons, Jr.—112 N. First St., Seneca (1963)
Dr. Murray T. Jackson—Conway Hospital, Conway (1963)
Dr. Donald G. Kilgore, Jr.—100 Mallard Street, Greenville (1963)
6. *Committee on Legislation and Public Policy*
Dr. Frank C. Owens, Chairman—1319 Laurel Street, Columbia (1963)
Dr. Bachman S. Smith, Jr.—77 Rutledge Avenue, Charleston (1962)
- Dr. James H. Gressette—920 Holly Street, Orangeburg (1962)
Dr. C. Tucker Weston, Jr.—1410 Barnwell Street, Columbia (1961)
Dr. Joseph I. Converse—413 N. Main Street, Greenville (1961)
Dr. Henry L. Laffitte—Allendale (1963)
Dr. Joseph P. Cain, Jr.—Mullins (Ex-officio)
Dr. Charles N. Wyatt—301 E. Coffee St., Greenville (Ex-officio)
Dr. Robert Wilson—165 Rutledge Avenue, Charleston (Ex-officio)
Mr. M. L. Meadors—309 W. Evans St., Florence (Ex-officio)
7. *Committee on Infant & Child Health*
Dr. Fred F. Adams, Jr., Chairman—157 Pine St., Spartanburg (1962)
Dr. Ethel M. Madden—1507 Hampton St., Columbia (1961)
Dr. John W. Rheney, Jr.—620 Carolina, N. E., Orangeburg (1963)
Dr. Patricia A. Carter—224 Calhoun St., Charleston (1962)
Dr. Thomas G. Herbert, Jr.—59 Bee Street, Charleston (1961)
Dr. William M. Bryan, Jr.—1433 Gregg St., Columbia (1963)
Dr. Samuel O. Cantey, Jr.—112 Witcover St., Marion (1962)
Dr. Joseph D. Thomas, Denmark (1961)
Dr. Lee C. Dimery—Duncan (1963)
8. *Committee on Welfare & Rehabilitation*
Dr. Ben N. Miller, Chairman—1433 Gregg St., Columbia (1963)
Dr. Roderick Macdonald—330 E. Main Street, Lancaster (1962)
Dr. John K. Webb—12 S. Calhoun St., Greenville (1961)
Dr. Weston C. Cook—1730 Hampton St., Columbia (1964)
Dr. Harry Mims, Charleston (1965)
9. *Committee on Liaison with Allied Professions*
Dr. H. M. Whitworth, Chairman—301 E. Coffee St., Greenville
Dr. N. B. Baroody, Jr.—Florence
Dr. Edwin D. Cochran—4 Catawba Street, Spartanburg
Dr. Edward R. Barber—Lancaster
Dr. A. B. Preacher—Allendale
Mr. M. L. Meadors, Florence (Ex-officio)
10. *Committee on School Health*
Dr. John R. Paul, Jr., Chairman—55 Doughty St., Charleston
Dr. Charles R. Propst—21 E. Calhoun St., Sumter
Dr. William B. Gamble, Jr.—16 Windermere Blvd., Charleston
Dr. Hilla Sheriff—Columbia (Ex-officio)

11. *Committee on Medical Education Foundation*
Dr. Howard Stokes—Chairman, Florence
Dr. R. L. Crawford, Lancaster
Dr. Thomas Gaines, Anderson
12. *Medical Advisory Committee to the Crippled Children's Society of S. C., Inc.*
Dr. J. I. Waring—82 Rutledge Avenue, Charleston, Chairman (1963)
Dr. William Weston, Jr.—1515 Bull St., Columbia, Co-Chairman (1963)
Dr. John A. Siegling—70 Ashley Ave., Charleston (1963)
Dr. John E. Keith—201 Prof. Bldg., Spartanburg (1963)
Dr. O. B. Mayer—1220 Pickens St., Columbia (1963)
Dr. Frank H. Stelling—9 Medical Ct., Greenville (1962)
Dr. James W. Jervey, Jr.—709 Dunbar St., Greenville (1962)
Dr. Harry W. Mims—55 Doughty St., Charleston (1962)
Dr. C. Guy Castles, Jr.—1417 Gregg St., Columbia (1962)
Dr. Walter Moore Hart, Florence (1962)
Dr. Sam G. Lowe, Jr.—237 S. Charlotte Ave., Rock Hill (1961)
Dr. Thomas G. Goldsmith—200 E. North St., Greenville (1961)
Dr. Julian P. Price—Florence (1961)
Dr. Phillip K. McNair—826 Waterloo Street, Aiken (1961)
Dr. John W. Bell—Greenwood (1961)
13. *Committee on Medical & Hospital Insurance Contracts*
Dr. Kenneth G. Lawrence, Chairman—Florence
Dr. John D. Gilland—Conway
Dr. A. C. Bozard—Manning
Dr. Joseph P. Cain, Jr.—Mullins (Ex-officio)
14. *Committee on Rural Health*
Dr. Harold S. Gilmore, Nichols
Dr. Harry A. Davis, Jr., Sumter
Dr. John Thomas, Loris
Dr. Wescoat A. Black, Beaufort
15. *Committee on Industrial Medicine*
Dr. George R. Dawson, Chairman—Florence
Dr. Ragsdale Hewitt, Sumter
Dr. Luther C. Martin, 82 Rutledge Avenue, Charleston
Dr. John M. Perry, Jr., Hartsville
16. *Committee on Coroners-Medical Examiners*
Dr. Harold R. Pratt-Thomas, Chairman—16 Lucas St., Charleston
Dr. William H. Hunter—Clemson
Dr. D. Strother Pope—1116 Henderson St., Columbia
Dr. James R. Cain—Columbia
Dr. Jack S. Scurry, Scurry Clinic, Greenwood
17. *Committee on Care of the Patient*
Dr. V. Wells Brabham, Jr., Chairman—950 Holly St., Orangeburg
Dr. Kirby D. Shealy—1419 Blanding St., Columbia
Dr. William H. Hunter—217 Pendleton Rd., Clemson
18. *Advisory Council to Woman's Auxiliary*
Dr. O. B. Mayer, Chairman—Columbia
Dr. J. Decherd Guess—Greenville
Dr. Richard W. Hanckel—Charleston
19. *Committee on Historical Medicine*
Dr. Joseph I. Waring, 82 Rutledge Ave., Charleston (Chairman)
Dr. Chapman Milling—1515 Bull St., Columbia
Dr. R. M. Pollitzer—211 E. Coffee St., Greenville
Dr. R. Eugene Zemp—1515 Bull St., Columbia
Dr. William A. Boyd, Columbia
20. *Fee Schedule Committee*
Dr. W. W. Edwards—Greenville (Chairman)
Dr. F. C. Owens—Columbia
Dr. John Siegling—Charleston
Dr. George Bunch—Columbia
(This Committee is to ask an Internist to consult with them)
21. *Medical Advisory Committee to Selective Service*
Dr. Frank C. Owens, Chairman
22. *Committee for the Study of the Care of the Aged*
Dr. R. L. Crawford, Chairman—Lancaster
Dr. William N. Cochran, Spartanburg
Dr. John A. Boone, Charleston
Dr. Joseph P. Cain, Jr. (Ex-officio)

THE MONTH IN WASHINGTON

Washington, D. C., July 9—Congress returned to work this month to take up its unfinished business, including the controversial issue of health care for the aged, an atmosphere dominated by election-year politics.

The three or four week, tag-end session of Congress loomed as one of the most important meetings in the past decade as far as possible impact on the medical profession is concerned.

The lawmakers are slated to decide whether to embark the Federal government on a course that could threaten the private practice of medicine, or to adopt a voluntary program that would pose no such danger.

The omnibus social security bill approved by the House Ways and Means Committee was easily cleared by the House, 381 to 23, and sent to the Senate Finance Committee, which held two days of hearings. The measure contained a voluntary, Federal-State program for assisting needy aged persons meet their health care costs. Both the Administration and the American Medical Association endorsed the House measure as in keeping with the concept of giving the states prime responsibility for helping their citizens, for aiding those who are most in need of help, and for avoiding the compulsory aspects of health plans involving the social security mechanism.

A vote by the Finance Committee, headed by Sen. Harry F. Byrd, (D., Va.) was scheduled shortly after the Senate resumed operations in August. Whatever action the Committee took, however, proponents of schemes such as the Forand bill to provide a compulsory, federal medical program promised a determined fight on the floor of the Senate.

In the event Congress should approve a government medicine plan, opponents were counting on a Presidential veto to kill the measure. The Chief Executive repeatedly has asserted in strong language his all-out opposition to any compulsory plan for health care financing.

At the Senate Finance Committee hearing, Arthur S. Flemming, Secretary of Health, Education and Welfare, renewed the Administration's flat stand against the social security avenue to financing health costs. Such a plan, he said, would inevitably lead to pressures for expanding the benefits and lowering or eliminating the age requirement. Under such circumstances, a 15 per cent or 20 per cent social security payroll tax would not be too far off, he said. "We believe it is unsound to assume that revenue possibilities from a payroll tax are limitless."

Dr. Leonard W. Larson, President-elect of the American Medical Association, told the Committee the House bill is the "antithesis of the centralized, socialized, statist approach of the proposals advocating national compulsory health insurance."

"To those critics who call this program modest, we say that fiscal irresponsibility, unpredictable cost and maximum nationalization are not the accepted criteria for good legislation," he testified.

A spokesman for the insurance industry pointed out "giant strides" made by private health insurance in recent years in covering aged persons. E. J. Faulkner declared that one of the most prevalent and erroneous assumptions on the matter is that most of the aged aren't able to contribute to financing their own health care costs.

The Social Security health bills, he said, "would impair or destroy the private practice of medicine, would add immeasurably to our already crushing tax burden, would aggravate our severe public fiscal problems, and would entail other undesirable consequences."

In other testimony, the AFL-CIO again urged enactment of a Social Security health bill; the

American Optometric Association and the International Chiropractors Association urged that health benefits included in any bill include the services of osteopaths and chiropractors, respectively.

On another legislative proposal of interest to the medical profession—the Keogh-Simpson bill—a Senate debate was scheduled this month. Sen. Gordon Allott (R., Colo.) said in a Senate speech that "I believe that this legislation will have the overwhelming support of this body."

The bill, which would encourage retirement savings by the self-employed such as lawyers, small businessmen and physicians, has already been approved by the House. The Senate bill, voted by the Senate Finance Committee, would require participating self-employed to establish retirement plans for their employees.

NEWS

Dr. W. E. Darby of Aiken has announced the closure of his practice of medicine to return for further hospital training effective June 30th.

Dr. Frank L. Culbertson, formerly of Laurens, S. C. has begun the practice of general medicine in Ridgeway and surrounding communities.

Dr. John H. Young, Columbia physician and surgeon, has been installed as president of the Columbia Lions Club.

MARION SIMS HOSPITAL STAFF

Dr. Joseph Miller Brice, Jr., an orthopedic surgeon from Rock Hill, has been appointed to the medical staff of Marion Sims Memorial Hospital.

It was announced that Dr. Brice will come to Lancaster to perform any emergency operations, and he will see referred or elective cases each Thursday afternoon in the out-patient department at the hospital.

Dr. Brice is a graduate of the Medical College of South Carolina and completed one year's rotating internship at Cook County Hospital, Chicago, Ill., in 1935. He served one year as assistant resident in surgery at Grady Hospital in Atlanta and for three years was a resident in orthopedic surgery at the Medical College of Virginia in Richmond.

STATE PRESIDENT

Dr. William S. Brockington of Greenwood was elected president of the South Carolina Surgical Society at its annual meeting in Spartanburg.

Other officers are Dr. John C. Hawk, director of the Medical College Hospital cancer clinic in Charleston, vice president, and Dr. John R. Timmons of Columbia, secretary-treasurer.

DR. CARROL BROWN GIVES UP GENERAL PRACTICE

Dr. Carrol Brown, Jr., who since 1930 has practiced medicine at Walterboro has announced that he is giving up his general practice as of July 1. He stated that he had found it necessary to do this as his x-ray work has grown to such an extent that he can not do justice to his other practice.

Dr. Brown did the x-ray work at the Charles EsDorn Hospital and has continued to do the x-ray work at Colleton County Hospital. He states that he reluctantly made this announcement but felt the only just thing to do was to devote his time to practice of radiology.

DR. LEWIS TO HEAD CHARLESTON HEALTH CLINIC

Dr. Newman M. Lewis, a graduate of Wake Forest College in North Carolina, will become officer in charge of the United States Public Health Service outpatient clinic in Charleston.

Dr. Lewis, 27, will report to Charleston in June to succeed Dr. Ronald C. Kelly, who is resigning from the service at the end of his two-year obligation. Dr. Kelly has been in charge of the Charleston clinic since the end of June, 1958.

The newly assigned Dr. Lewis will go to Charleston from Staten Island Public Health Service Hospital, where he has served for the last year. Prior to that, he was at the Public Health Service Hospital in Memphis.

A 1954 graduate of Wake Forest College, Dr. Lewis received his doctor of medicine degree in 1957. He served an internship at North Carolina Baptist Hospital before entering the Public Health Service in July, 1958.

Niles A. Borop, M. D. and Kenneth N. Owens, M. D. announce their association for the practice of Gynecology and Obstetrics, July 1, 1960 at 130 Waterloo Street, Aiken.

DR. W. J. VERNON AT PIEDMONT

Dr. W. J. Vernon, who practiced medicine at Pelzer until two years ago, has returned to Piedmont.

At present he is sharing Dr. R. L. Hallman's office but expects to set up his own separate office.

Dr. Vernon is a native of Cheraw. He graduated in pharmacy at the University of South Carolina and went on to complete requirements for a medical degree in 1951 at the Medical College of South Carolina. He interned at Greenville General Hospital and entered practice at Pelzer going to Georgetown to practice two years ago.

DR. L. S. CONNOR, III

Dr. L. S. Connor, III, of Holly Hill and his family have moved to Springfield and Dr. Connor has opened offices for the practice of general medicine on Railroad Ave.

Dr. Connor holds a bachelor's degree from Wofford

College in natural sciences and a master's degree from the University of South Carolina in education. After being in public school work for several years at Eutawville, he served in the U. S. Navy as an engineering officer during World War II and the Korean Conflict.

Later, he trained at the Medical College of South Carolina and interned at Orangeburg Regional Hospital.

TWO DEANS NAMED AT MEDICAL COLLEGE

Dr. H. R. Pratt-Thomas and Dr. Vince Moseley have been named deans at the Medical College of South Carolina.

Dr. Pratt-Thomas' appointment as dean of the School of Medicine and Dr. Moseley's appointment as dean of clinical medicine, were announced by Dr. Thomas A. Pitts of Columbia, chairman of the Medical College's board of Trustees.

They assumed their posts July 1.

Dr. Pratt-Thomas, who is professor of pathology at the Medical College and active in cancer research, will succeed Dr. John T. Cuttino, who becomes president of the Medical College July 1, following the retirement of Dr. Kenneth M. Lynch.

Dr. Moseley, who is professor of medicine and co-chairman of the department of medicine, has been head of the clinical work at the Medical College Hospital and director of the out-patient clinic for several years. His promotion makes him the first dean of Clinical Medicine at the Medical College. He will continue to teach in the Department of Medicine.

Dr. Pratt-Thomas is a graduate of Davidson College and the Medical College of South Carolina. Dr. Moseley attended Clemson, transferring to Duke University after two years of study. He is a graduate of the Duke University School of Medicine.

ROPER AWARDED RESEARCH GRANT

Roper Hospital has added \$65,045 to its research budget, the grant coming from the John A. Hartford Foundation, Inc., of New York and ticketed for research on arteries.

The grant, the third made to the hospital by the Hartford Foundation, brings to \$232,336 the amount of money which Roper has received from the organization. The money is being used to investigate diseases of the arteries and develop new methods of diagnosis and treatment.

The research is in cooperation with the Medical College of South Carolina. Some of the information brought out in the studies has already been put into use on patients. Included in the advances made possible by the research are the development of a better synthetic material for replacement of diseased blood vessels, and improved surgical methods for conducting these operations.

Through the research program, the hospitals have also been able to improve their use of the "artificial heart" in surgery. The study has also improved doc-

tors' knowledge of the effect of various drugs in heart treatment.

MEDICAL COLLEGE FUNDS

The Department of Health, Education and Welfare approved two Hill-Burton grants amounting to \$104,880 for renovation and expansion of facilities at the South Carolina Medical College in Charleston.

Senators Strom Thurmond and Olin Johnston and Rep. Mendel Rivers said one of the grants, in the amount of \$35,000, will go towards \$70,000 worth of renovations and expansion of existing outpatient facilities at the Medical College Clinic.

The other grant, amounting to \$79,880.50, will be used in constructing an addition to the college's diagnostic and treatment center, which will cost a total of \$157,761.

South Carolina must put up the remaining funds necessary to complete the work in each instance.

DR. PRICE HEADS AMA TRUSTEES

Dr. Julian P. Price, Florence is new chairman of the American Medical Association's Board of Trustees.

A pediatrician, Dr. Price succeeded Dr. Leonard W. Larson, who was named president-elect of the Association. For the past two years, Dr. Price served as vice-chairman of the Board. He has been a member of the Board since 1953.

Dr. Price was born in Sinehang, China, Oct. 22, 1901. He received AB and MA degrees from Davidson College, and then earned his MD from Johns Hopkins in 1926.

A physician with a literary flair, Dr. Price wrote *The Young Doctor Who Thinks Out Loud*, which was published in 1931.

He was editor of the Journal of the South Carolina Medical Association from 1941-53, and has contributed numerous articles to other medical journals.

Dr. Price is medical director of the South Carolina Crippled Children's Home.

AMA News

REUNION OF CLASS OF 1910

Members of the Medical College of South Carolina's 1910 class held their 50th reunion at Hotel Columbia, Columbia, S. C., Wednesday, May 25th. Those attending were Dr. R. R. Prentiss of Meggett; Dr. C. E. Crosby of Greenwood, Dr. W. L. Heaner of Orangeburg; Dr. William A. Smith of Charleston; Dr. Henry J. Stuckey of Bamberg; Dr. Charles P. Mobley of Orangeburg, Dr. M. W. Cheatham of Columbia; Dr. George A. Hennies of Lake Junaluska, N. C. (formerly of Chester); Dr. Eugene G. Peak of Ocala, Fla.; Dr. Marion H. Wyman of Columbia, and Dr. Paul K. Switzer of Union. Dr. Warren Burgess of Sumter and Dr. Theo. DuBose of Columbia were unable to attend. Dr. Harry Mustard, former com-

missioner of health of New York City who now lives at Boykin, also attended. He was in the class of 1911. Forty-two persons were in the 1910 class.

Morey Lipton, M. D. announces the opening of his office at 51-C Montague Street, Charleston.

Practice limited to General Surgery.

Maxcy C. Harrelson, Jr., M. D. announces his return to practice of Obstetrics and Gynecology at 71 Gadsden Street, Charleston.

Dr. Jack W. Chandler, Jr., 34 Mason Croft Drive, Sumter, S. C., has been awarded a Wyeth Laboratories pediatric residency fellowship, it was announced recently by Dr. Philip S. Barba, past president of the American Academy of Pediatrics and chairman of the selection committee.

Dr. Chandler will take his residency training at the Medical College of South Carolina from which he received his medical degree. The fellowship recipient completed his internship at Medical Center Hospitals, Charleston, S. C., and recently served as chief of outpatient services at Greenville, (Miss.) Air Force Base Hospital.

At the recent meeting of the AMA at Miami Beach, Dr. George D. Johnson of Spartanburg was elected to the Council on Constitution and By-Laws.

The five hundred dollar contribution which the Council of the S. C. Medical Association agreed to donate to help defray the expenses of the meetings along with six other states, namely, Florida, Alabama, Tennessee, North Carolina, Virginia, and Georgia, proved to be most helpful. The Hawaiian Room was used to entertain guests where South Carolina furnished towels, handkerchiefs, textiles and pamphlets of the locations of historical points in our state. The South Carolina Development Board and the State Chamber of Commerce, Mr. John Floyd, Executive Secretary, were most cooperative.

On Sunday, June 12th, there was a meeting of the State Officers in the Americana Hotel Ballroom where addresses were made by several outstanding individuals. Mr. Paul Butler, Chairman of the National Democratic Party insulted the American Medical Association and its members, threatening that the Forand Bill would be included in the Democratic Platform for 1960. Mr. Morgan, the Secretary of the National Republican Party gave a short and splendid talk saying that the measures which came up for dispute in the House, that is, Congress, and the Senate, were delegated to be settled on a local and state-wide basis whereas the Democratic theory and practice was to let the Federal Government take over the situation and not allowing the states any voice. He certainly made many friends for the Republican Party.

William Weston, Jr.

DEATHS

DR. E. E. STRONG

Dr. Edgar Ellis Strong, Jr., 53, beloved by hundreds of York people as the traditional family doctor, died June 21 in Ocean View Memorial Hospital, Myrtle Beach, S. C., where he was vacationing.

He was born in November, 1906, a son of the late E. E. Strong, Sr., and Mrs. Julia Stewart Strong. He received his education at Erskine College, University of Tennessee Medical College, and served as intern at Garfield Memorial Hospital, Washington, D. C. He had practiced medicine in York since 1938, and prior to that time in Blacksburg.

He was a past president of the York County Medical Society, an elder in the ARP Church in York; director of the Bank of York; a member of the White Rose Club; a member of the Crust Breakers; a charter member of the Rotary Club, and 11 years, a chairman of the board of trustees, York School District No. 1.

A quiet, reserved man, he took great interest in his patients, and in addition to his practice, his other interests were hunting, fishing, skeet shooting, and the violin.

His patients voiced one complaint. They often said he didn't charge enough. He often charged his patients nothing at all if he felt they were unable to pay.

Four years ago, he suffered a heart attack and was unable to practice for nearly a year. Since that time, he had resumed a limited practice.

There will be a memorial fund in memory of Dr. Edgar E. Strong, Jr., but the exact nature of the memorial has not been determined. A bronze plaque has been suggested by the sponsors. It would be placed in Divine Saviour Hospital in York. In addition to the plaque, the possibility of furnishing a room in memory of Dr. Strong also has been suggested. A new wing is to be constructed at the hospital.

DR. J. I. BEDENBAUGH

Dr. James Ira Bedenbaugh, retired physician of Prosperity, died recently in Columbia after a lingering illness.

He was born in Prosperity, S. C., graduated from Newberry College in 1895 and received his M. D. degree from the University of Georgia in 1903. He practiced in the Prosperity community for the past 60 years. A few years ago he was recognized for his long service in the medical profession.

He was a member of the South Carolina Medical Association, the Newberry County Medical Association, the Prosperity Town Council and the school board. He also was chairman of the Commissioners of Public Works, a Mason and a Shriner.

ANNOUNCEMENTS

The 1960 Annual Meeting of the Southern Trudeau Society (and the Southern Tuberculosis Conference) will be held on September 14, 15, and 16, 1960, at the Hotel Francis Marion, in Charleston, South Carolina.

SOUTHERN THORACIC SOCIETY THURSDAY, SEPTEMBER 15, 1960 CHARLESTON, S. C.

1. Tuberculosis in Infancy and Childhood—An Experience in Charleston, S. C.
Presented by Jack R. Paul, M. D., Charleston, S. C.
Discussed by David B. Gregg, M. D., Charleston, S. C.
2. Tuberculin Skin Testing.
Presented by Daniel E. Jenkins, M. D., Houston, Texas
Discussed by Victor C. Vaughn, III, M. D., Augusta, Ga.
3. The Treatment of Tuberculosis in Infancy and Childhood.
Presented by Edwin L. Kendig, Jr., M. D., Richmond, Va.
Discussed by J. I. Waring, M. D., Charleston, S. C.
4. BCG and Chemotherapy in the Prevention of Complications of Primary Tuberculosis in Children.
Presented by Sarah F. Davis, M. D., Birmingham, Ala.
Discussed by Edwin L. Kendig, Jr., M. D., Richmond, Va.
5. Resection for Pulmonary Tuberculosis—A Review and Analysis in over Fifty Resections.
Presented by J. L. Wofford, M. D., Watts R. Webb, M. D. and H. K. Stauss, M. D., Jackson, Miss.
Discussed by Edward F. Parker, M. D., Charleston, S. C.

Thursday Noon Luncheon

Clinical Applications of Lung Function Testing.
George W. Wright, M. D., Cleveland, Ohio

Thursday Afternoon, September 15, 1960

1. The Detection of Early Pulmonary Emphysema—Mass Survey Technique
Presented by Ben V. Branscomb, M. D., Birmingham, Ala.
Discussed by George W. Wright, M. D., Cleveland, Ohio and Ross L. McLean, M. D., Atlanta, Ga.
2. Alveolar Ducts in Emphysema—Studies by X-Ray Microscopy and other Methods.
Presented by Charles Odeer, M. D., New Orleans, La.
Discussed by Herbert C. Sweet, M. D., St. Louis, Mo. and George W. Wright, M. D., Cleveland, Ohio.
3. Pulmonary Disease Caused by Atypical Mycobacteria. Dallas Experience.
Presented by Charles A. LeMaistre, M. D. and Hal

J. Dewlett, M. D., Dallas, Texas.

Discussed by John H. Seabury, M. D., New Orleans, La.

4. Pulmonary Disease Caused by Atypical Mycobacteria. Batey Experience.

Presented by Raymond F. Corpe, M. D., Rome, Ga.
Discussed by Albert G. Lewis, Jr., M. D., Tampa, Fla.

Friday Morning, September 16, 1960

1. Methyl Prednisolone in the Treatment of Pulmonary Tuberculosis.

Presented by J. Richard Johnson, M. D., Madison, Wis.

Discussed by Ross L. McLean, M. D., Atlanta, Ga.

2. Co-Existing Histoplasmosis and Tuberculosis.

Presented by A. H. Smith, M. D., State Sanatorium, Ark.

Discussed by Harry E. Walkup, M. D., Oteen, N. C.

3. The Surgical Treatment of Pleural Complications.

Harry E. Walkup, M. D., Oteen, N. C.

Discussed by Edward F. Parker, M. D., Charleston, S. C.

**S. C. CHAPTER AMERICAN
ACADEMY GENERAL PRACTICE
12TH ANNUAL MEETING
MEMORIAL AUDITORIUM**

**Spartanburg, S. C.
September 29 - 30, 1960**

Dr. Claude Frazier

"Practical Methods of Determining the Cause of Allergy."

"Some Do's and Don't's of Allergic Management."

Dr. Walter Frommeyer

"Fibrinolytic Enzymes and Clinical Hemorrhage."

"Anemia and the Malabsorption Syndromes; Etiology and Management."

Dr. John Siegling

"Fractures in Children are Different."

"Office Orthopedic Problems."

Dr. William Kirtley

"Modern Therapy in Diabetes Mellitus."

"Complications of Diabetes Mellitus."

Dr. Bert Leming

"Bacteriology."

Dr. John Sites

"Gynecities and Toxemia of Pregnancy."

Dr. Edward S. Orgain

"Controversial Problems related to the treatment of Coronary Artery Disease."

"Heart Disease 1960."

**TENNESSEE VALLEY MEDICAL
ASSEMBLY**

READ HOUSE

Chattanooga, Tennessee

September 26 - September 27, 1960

REHABILITATION

A worldwide interchange and sharing of knowledge in the fields of rehabilitation and employment of the physically handicapped will take place when the Eighth World Congress of the International Society for the Welfare of Cripples meets August 28 to September 2, 1960 at the Waldorf-Astoria Hotel in New York.

The Congress will take a dynamic approach to solving or alleviating problems of crippling as well as establishing a common basis for effort among nations worldwide.

Held for the first time outside Europe, the Congress will evolve from plans shaped by more than 100 U. S. citizens. The National Society for Crippled Children and Adults — the Easter Seal Society — will be host of the meeting.

A-WAY HOSPITAL

On May 3, 1960 the Gaston Memorial Hospital building was re-opened as the A-Way Hospital at Travelers Rest, S. C.

Mr. George Coleman, Sr., Mr. George Coleman, Jr. and Dr. M. Gordon Howle are the owners and operators. The Hospital has been separated into two separate and distinct units, one for the care, treatment, and rehabilitation of alcoholics, the other for the care and treatment of ambulatory aged patients.

Urology Award—The American Urological Association offers an annual award of \$1000 (first prize of \$500, second prize \$300, and third prize \$200) for essays on the result of some clinical or laboratory research in Urology. Competition is limited to Urologists who have been graduated not more than ten years, and to hospital internes and residents doing research work in Urology.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel Biltmore, Los Angeles, California, May 22-25, 1961.

For full particulars write the Executive Secretary, William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before December 1, 1960.

THE MEDICAL COLLEGE OF GEORGIA

Four intensive post-graduate courses patterned for the practitioner are planned for the fall and winter 1960-61 at the Medical College of Georgia, Augusta. Featured faculty will include nationally known figures as Dr. Crawford J. Campbell, Chief Orthopedist at Albany, N. Y. Medical College; Dr. Alexander Marble, diabetic authority from Harvard University; Dr. Warren Wheeler, pediatrician of Ohio State University; and Dr. Edgar A. Hines, Jr., vascular disease authority from the Mayo Clinic.

"Fractures in General Practice" is scheduled for Nov. 29, 30, Dec. 1; "Workshop on Diabetes" Dec. 6, 7, 8; "Problems of the Newborn Infant" Jan. 24,

25, 26; "Management of your Patient with Vascular Disease" Feb. 28, Mar. 1, 2. The featured speakers will be supplemented by members of the faculty of the Medical College of Georgia.

Each course is acceptable for 18 hours of credit by the American Academy of General Practice and registration is limited to a small group for close participant-faculty communication. Registration fee is \$50.00 for each session. Application may be made by contacting Dr. Claude-Starr Wright, Director, Department of Continuing Education, Medical College of Georgia, Augusta.

DUKE POSTGRADUATE CRUISE

The 5th Medical Seminar Cruise to the West Indies sponsored by Duke University School of Medicine will be held November 9-18, 1960. The medical seminar constitutes 20 hours credit of acceptable Category I Postgraduate Requirements A.A.G.P. A certificate for the number of hours of credit will be issued if desired. Instruction will be held on board ship, *M. S. Kungsholm*, and the program should be of interest to the specialist as well as the generalist.

For further medical details, address Director of Postgraduate Education, Duke University School of Medicine, Durham, North Carolina. For registration and cruise information, write Allen Travel Service, Inc., 565 Fifth Avenue, New York 17, N. Y.

The *Kungsholm* leaves from New York November 9th. Rates from \$230.

The Birmingham Academy of Medicine's Third Medical Progress Assembly will be held September 18-20 at the Dinkler-Tutwiler Hotel in Birmingham, Alabama. With a faculty of 16 lecturers from leading American medical institutions, the Medical Progress Assembly expects to set a new attendance record.

POSTGRADUATE MEDICAL SEMINAR CARIBBEAN CRUISE

Sponsored by the University of Florida College of Medicine and the Florida Medical Association. October 12-23, 1960.

For reservation write to:

Mr. E. M. Baskette, Sou. Reg. Mgr.
Caribbean Cruise Lines
Roper Building
Miami 32, Florida

NINTH U. S. CIVIL DEFENSE COUNCIL CONFERENCE MEDICAL - HEALTH SECTION

September 21-22, 1960

Minneapolis, Minnesota

Leanington Hotel

The Fifth International Congress on Nutrition will meet at the Sheraton Park and Shoreham Hotels in Washington, D. C., September 1 to 7, 1960. Begin-

ning in 1946, former Congresses have been held in England, Switzerland, the Netherlands, and France. This will be the *first* time one has been held in the United States.

FROM THE PRESS

HOSPITAL NEEDS

South Carolina's hospital needs, described as particularly acute in the fields of rehabilitation, chronic disease, nursing homes, and mental treatment, were reviewed June 9 by the state's hospital advisory council.

The Hospital Construction Division of the State Board of Health has completed the state plan for construction of hospital and related facilities during 1960-61. A 27-member group is charged with approving plans and priorities for construction allotments of federal funds made available through the Hill-Burton act.

During the last 13 years, South Carolina has received an average allotment of \$2,600,000 a year for hospital construction from Hill-Burton funds. The state, however, has not been using its share of federal funds for rehabilitation facilities and those funds have been apportioned among other states.

A growing need for hospitalization in South Carolina is related to the increased demand for such care from the aged residents of the state. Persons over 65, consume hospital services at twice the rate of younger people. Only two counties (Greenville and Spartanburg) have provided nursing home facilities for the aged under the Hill-Burton program.

The Marion Sims Memorial Hospital at Lancaster currently is sponsoring a nursing home as a part of the general hospital. The hospitals at Chester and at Conway likewise are considering projects similar to that at Lancaster.

Only 12 per cent of the need for nursing home facilities in South Carolina is now being met. The need for general hospitals has been met to the extent of 62 per cent; for tuberculosis hospitals, 83 per cent; for mental hospitals, 18 per cent, but for chronic patient hospitals, only four per cent.

The revised state plan for 1960-61 was available for inspection by interested persons up until June 15, after which time it was sent to the U. S. Public Health Service for approval. Once approved, it will be printed and distributed in South Carolina.

Evening Herald (Rock Hill)

DR. STRONG: THE FAMILY DOCTOR

The medical profession, which prides itself on its professional ethics, lost one of its most respected members with the death of Dr. E. E. Strong, Sr. of York.

Dr. Strong, gentle and soft spoken, carried his own ethics far beyond even the high ones of his profession.

His entire career was one of service but it was

even more than the required service—his was a warm, personal service. Those who sought his services were more than patients to him. They were individual people in whom he took a deep personal interest.

Dr. Strong's patients were charged according to their ability to pay. When they could not pay, they were not charged at all. To Dr. Strong, the only important factor involved was that he serve those who needed his help.

He was the traditional family doctor—in the warmest, truest and most self-sacrificing sense.

The medical profession sets its standards of ethics high for its members. Dr. Strong set his even higher.

Evening Herald (Rock Hill)

William H. Cain, M. D. announces the opening of his office at 4 Vanderhorst Street, Charleston, South Carolina for the practice of General Surgery.

Frank L. Culbertson, M. D., announces the opening of his offices for the general practice of medicine, in Ridgeway, South Carolina.

STATE APPOINTMENTS ANNOUNCED

Governor Ernest F. Hollings recently announced a series of state-wide appointments.

Dr. Harold E. Jervey, Jr., of Columbia, and Dr. Harold S. Gilmore of Nichols, were reappointed members of the State Board of Medical Examiners, and V. F. Platt, Jr., of Conway was named a member of the executive committee of the State Board of Health to succeed the late V. F. Platt.

COLUMBIA MEDICAL SOCIETY DINNER HELD

The Columbia Medical Society held their June scientific dinner meeting, June 6th at the Veterans Administration Hospital.

Dr. John H. Moyer, professor of medicine and chairman of the Department of Internal Medicine at Hahnemann Medical College and Hospital, Philadelphia, Pa., made the main address.

James E. Padgett, Jr., M. D. announces the opening of his office on July 1, 1960 for the practice of Pediatrics at 233 Barnwell Street, Aiken, South Carolina.

REPORT ON ACTIONS OF THE HOUSE OF DELEGATES AMERICAN MEDICAL ASSOCIATION 109th ANNUAL MEETING JUNE 13-17, 1960 MIAMI BEACH

Health care for the aged, pharmaceutical issues, occupational health programs, relations with allied health groups and relations with the National Foundation were among the major subjects involved in policy actions by the House of Delegates at the American Medical Association's 109th Annual Meeting held June 13-17 in Miami Beach.

Dr. Leonard W. Larson of Bismarck, N. D., former chairman of the A. M. A. Board of Trustees and of the A. M. A. Commission on Medical Care Plans, was named president-elect by unanimous vote. Dr. Larson will succeed Dr. E. Vincent Askey of Los Angeles as president at the Association's annual meeting in June, 1961, at New York City.

The A. M. A. 1960 Distinguished Service Award, one of medicine's highest honors, was given to Dr. Charles A. Doan, who will retire next year as dean of the Ohio State University College of Medicine and director of the Health Center in Columbus, Ohio.

Total registration through Thursday, with half a day of the meeting still remaining, had reached 19,107, including 8,706 physicians.

Health Care For The Aged

After considering a variety of reports, resolutions and comments on the subject of health care for the aged, the House of Delegates adopted the following statement as official policy of the American Medical Association:

"Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state, and only when all these fail, to the federal government, and then only in conjunction with the other levels of government, in the above order. The determination of medical need should be made by a physician and the determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved. The use of tax funds under the above conditions to pay for such care, whether through the purchase of health insurance or by direct payment, provided local option is assured, is inherent in this concept and is not inconsistent with previous actions of the House of Delegates of the American Medical Association."

The House also urged the Board of Trustees "to initiate a nonpartisan open assembly to which all interested representative groups are invited for the purpose of developing the specifics of a sound approach to the health service and facilities needed by the aged, and that thereafter the American Medical Association present its findings and positive principles to the people."

In connection with an educational program regarding the aged, the House declared that "the American Medical Association increase its educational program regarding employment of those over 65, emphasizing voluntary, gradual and individualized retirement, thereby giving these individuals not only the right to work but the right to live in a free society with dignity and pride."

Earlier, at the opening session, Dr. Louis M. Orr, retiring A. M. A. president, had asked the House to go on record favoring more jobs for the aged, voluntary retirement and a campaign against discrimination because of age, whether it be 40 or 65. The House also gave wholehearted approval to Dr. Askey's

urging that state medical societies take an active part in state conferences and other planning activities preceding the January, 1961, White House Conference on Aging.

Pharmaceutical Issues

In the pharmaceutical area the House took two actions—one regarding mail order drug houses and the other involving the development and marketing of pharmaceutical products.

The House agreed with representatives of the pharmacy profession that the unorthodox practice of mail order filling of prescription drugs is not in the best interest of the patient, except where unavoidable because of geographic isolation of the patient. The statement pointed out that in this process the direct personal relationship, which exists between the patient-physician-pharmacist at the community level and which is essential to the public health and the welfare of patients, is lost.

The House also directed the Board of Trustees to request the Council on Drugs and other appropriate Association councils and committees "to study the pharmaceutical field in its relationship to medicine and the public, to correlate available material, and after consultation with the several branches of clinical medicine, clinical research, and medical education and other interested groups or agencies, submit an objective appraisal to the House of Delegates in June, 1961." The statement pointed out that certain proposals have been made which, if carried out, might impair the future of pharmaceutical research and development, thus retarding the progress of scientific therapy. It also said that the services of the pharmaceutical industry are so vital to the public and to the medical profession that an objective study should be made.

Occupational Health Programs

The House approved a revised statement on the "Scope, Objectives and Functions of Occupational Health Programs," which was originally adopted in June, 1957. The new statement contains no fundamental alterations in A. M. A. policy or ethical relationships, but it adds important new material on the following points:

1. Greater emphasis on the preventative and health maintenance concepts of occupational health programs.
2. A more positive statement of organized medicine's obligation to provide leadership in improving occupational health services by part-time physicians in small industry.
3. Increased emphasis on rehabilitation of the occupationally ill and injured.
4. Inclusion of the proper use of immunization procedures for employees, as approved by the House in 1959.
5. A more adequate statement on the need for teamwork with lay industrial hygienists in tailoring each occupational health program to the particular employee group involved.

In approving the revised guides for occupational

health programs, the House also accepted a suggestion that the A. M. A. Council on Occupational Health undertake a project to study and encourage the employment of the physically handicapped.

Allied Health Groups

The House approved the final report of the Committee to Study the Relationships of Medicine with Allied Health Professions and Services and commended it as "a monumental work." The report covers the present situation, future implications and recommendations, including guiding principles and approaches to activate physician leadership. The House strongly recommended that A. M. A. activity in this vitally important area be continued and it approved the appointment of a Board of Trustees committee to carry on the work.

To develop physician leadership in promoting cooperative efforts with allied health professions and services, the report suggested the following A. M. A. activities:

1. A general conference should be held with allied scientists in the basic medical sciences and related disciplines for discussion of matters of concern related to the creation of permanent, cooperative activities.
2. Specific exploratory conferences should be held with members of segments of science allied to a given area of medical practice with the national medical organizations concerned.
3. General and specific conferences should be held with professional and technical assistants on education, recruitment and coordination of contributions.
4. Through meetings and publications, reciprocal exchange of information should be provided between physicians and allied scientists and members of health professions.
5. Effective, continuing liaison should be established between A. M. A. representatives and professional and technical personnel.

National Foundation

The House took two actions involving relations between the medical profession and the National Foundation. It adopted a statement of policies for the guidance of state medical associations and recommended that they be adopted by all component medical societies. These policies cover such subjects as membership of medical advisory committees at the chapter level, the function of these committees, and basic principles concerning financial assistance for medical care, payment for physicians' services and physicians' responsibilities for constructive leadership in medical advisory activities.

In another action the House directed the Board of Trustees to authorize further conferences with leaders in the National Foundation on the problem of poliomyelitis as it relates to the betterment of the public health and to consider further joint action toward the eradication of polio. The House commended the National Foundation for its outstanding service in the attack against polio, but pointed out that much work

remains to be done in public education, vaccination, continuing assistance for polio victims and continued research.

Miscellaneous Actions

In dealing with reports and resolutions on a wide variety of other subjects, the House also:

Strongly reaffirmed its support of the *Blue Shield concept* in voluntary health insurance and approved specific recommendations concerning A. M. A.-Blue Shield relationships;

Approved a contingent appointment of not more than 6 months for *foreign medical school graduates* who have been accepted for the September, 1960, qualification examination;

Agreed that the American Medical Association should sponsor a *second National Congress on pre-paid health insurance*;

Approved a Board of Trustees request to the Postmaster General for a stamp commemorating the *Mayo brothers*;

Decided that the establishment of a home for *aged and retired physicians* is not warranted at this time.

Approved the establishment of a new "*Scientific Achievement Award*" to be given to a non-physician scientist on special occasions for outstanding work;

Approved the following schedule for future *annual meetings*: Atlantic City, 1963; San Francisco, 1964, and New York City, 1965;

Approved the objectives of the A. M. A. *Commission on the Cost of Medical Care* established by the Board of Trustees and headed by Dr. Louis M. Orr, immediate past president of the Association;

Urged individual members of the Association to take a greater interest and more active part in *public affairs* on all levels;

Reaffirmed its opposition to compulsory inclusion of physicians under Title II of the *Social Security Act* and recommended immediate action by all A. M. A. members who agree with that position;

Called for a review of existing and proposed legislation pertaining to *food and color additives*, with the objective of supporting appropriate measures which are in the public interest;

Urged reform of the *federal tax structure* so as to return to the states and their political subdivisions, their traditional revenue sources;

Asked state and county medical societies to make greater use of A. M. A. *recruitment materials* in presenting medicine's story to the nation's high schools;

Requested the Board of Trustees to initiate a study of present policy regarding the required content and method of preparing *hospital records*;

Commended the Department of Defense and the Air Force for establishing and operating the *Aero-medical Transport Service* and urged that it be maintained at optimum efficiency;

Directed the Board of Trustees to develop *group*

annuity and *group disability* insurance programs for Association members; and

Expressed grave concern over the indiscriminate use of *contact lenses*.

Addresses and Awards

Dr. Orr, in his final report to the House at the opening session, urged medical societies to "adopt" rural villages, cities and regions in underdeveloped parts of the world and to send them medical, clinical and hospital supplies.

Dr. Askey, in his inaugural address Tuesday night, declared that medicine faces its greatest challenge in the decade ahead, adding that physicians must prove the effectiveness of medicine practiced in a free society. Dr. John S. Millis (PhD), president of Western Reserve University, Cleveland, Ohio, and guest speaker at the inaugural ceremonies, said the human dilemma of the sixties is an increasing desire for security and authority with a diminishing desire for responsibility.

At the Wednesday session of the House, Dr. Askey urged intensified, accelerated effort in five areas—medical education, preparations for the White House Conference on Aging next January, health insurance and third party relationships, mental health, and membership relations.

The Goldberger Award in Nutrition was presented to Dr. Richard Vilter of the University of Cincinnati. The Boy Scouts of America, celebrating its golden jubilee, presented the A. M. A. with a citation in appreciation of the medical profession's help and support. Dr. B. E. Pickett of Carrizo Springs, Texas, retiring chairman of the Council on Constitution and Bylaws, received an award in recognition of his long service.

Election of Officers

In addition to Dr. Larson, the new president-elect, the following officers were named at the Thursday session:

Dr. William F. Costello of Dover, N. J., vice president; Dr. Norman A. Welch of Boston, re-elected speaker of the House, and Dr. Milford O. Rouse of Dallas, Texas, re-elected vice speaker.

Dr. Gerald D. Dorman of New York City was elected to the Board of Trustees to succeed Dr. Larson, and Dr. James Z. Appel of Lancaster, Pa., was re-elected to the Board.

Elected to the Judicial Council, to succeed Dr. Louis A. Buie of Rochester, Minn., was Dr. James H. Berge of Seattle.

Named to the Council on Medical Education and Hospitals were Dr. William R. Willard of Lexington, Ky., succeeding Dr. James M. Faulkner of Cambridge, Mass., and Dr. Harlan English of Danville, Ill., who was re-elected.

On the Council on Medical Service, the House re-elected Dr. Russell B. Roth of Erie, Pa., and Dr. Hoyt B. Woolley of Idaho Falls.

Dr. George D. Johnson of Spartanburg, S. C., was

named to succeed Dr. Pickett on the Council on Constitution and Bylaws.

F. J. L. Blasingame, M. D.
Executive Vice President
American Medical Association

BOOK REVIEWS

THE TEEN-AGE YEARS, by Arthur Roth, M. D. First Edition. Doubleday and Company Inc., Garden City, New York. 1960. Price \$3.95.

Dr. Arthur Roth has produced in "The Teen-Age Years" an excellent reference manual for parents and other laymen who come in contact with adolescents. In the past the adolescent has been in the rather unhappy position of falling between pediatrician and internist. Dr. Roth has recognized the need for special consideration of this particular age group.

"The Teen-Age Years" takes into consideration not only the emotional factors which arise during this rather critical period of life, but the usual and sometimes peculiar medical problems which arise during this period. A quick look at the contents page of "The Teen-Age Years" indicates the extent to which Dr. Roth has gone in trying to assess all of the problems faced by the teenager. Not only does Dr. Roth take into consideration the problems of changing from boy into man, and girl into woman, but touches on many of the small and bothersome things which beset the teenager. Things which might ordinarily be considered minor to the adult are dealt with carefully for the teenager. Dr. Roth deals with such things as blushing, fainting, skin eruptions, causes of fatigue, and growing pains. The book contains 284 pages printed in easily readable type. Dr. Roth's style is clear and concise. I do not feel that it is designed for physicians, though I believe that any physician who treats more than a few teenagers would be profited by reading this work. I am unable to compare Dr. Roth's book to any other similar work because I know of no book designed to meet the needs of the teenager. Nonetheless, I would strongly recommend the book as a sequel to Dr. Spock's work on children.

George H. Orvin, M. D.

HANDBOOK OF POISONING — DIAGNOSIS AND TREATMENT—2ND EDITION. Robert H. Dreisback—Lange Medical Publications, Los Altos, California. Price \$3.50. (Revised Every Two Years)

This is a small sized handbook 4" x 7" suitable for carrying in physician's bag for quick reference. The book is well arranged for ready reference. The first section discusses general considerations and emer-

gency treatment of poisons and poisoning. The later sections discuss by groups the more common pesticides, industrial hazards, household chemicals, medicinal poisons and plant and animal hazards. Each of these latter sections gives in outline form the chemistry of the substance, clinical findings divided into acute, chronic and laboratory findings and the treatment including prophylaxis and prognosis. The information is presented concisely and the book is well indexed. In addition, a chapter is devoted to illustrations and instructions for use of the more frequently available resuscitation and oxygen equipment which would be invaluable to the occasional user of such equipment.

Margaret Jenkins, M. D.

COMMUNICABLE AND INFECTIOUS DISEASES, 4th ed., by Franklin H. Top, M. D. C. V. Mosby Co., St. Louis, Mo., 1960. Price \$20.00.

This is the fourth edition of a book which has received wide acceptance and approval and which is considered as the standard book of reference on the subjects included. It is well arranged, well printed, and well illustrated with very good color photos as well as other prints. The book is primarily attributable to Dr. Top, but there are a number of able collaborators whose names are attached to certain chapters of the book. Perhaps they have all collaborated in those chapters which are not so designated. Despite the difference in authorship, the writing is pleasing throughout, and rather long, perhaps almost elaborate, lists of references are given after a number of the chapters.

This book should be most useful to anyone dealing with the communicable diseases.

JIW

A PRACTICAL GUIDE TO GENERAL SURGICAL MANAGEMENT, Julian A. Sterline, M. D. Vantage Press, Inc., New York, 1960. 64 pages. Price \$3.00.

This book, as explained by the author, was written as a reference for interns and residents assigned to the surgical ward service of a hospital. It describes the responsibility of each member of the team who cares for patients with surgical problems. This book would be valuable to the intern or first year surgical resident in his introduction to the routines of a surgical service and ward. It has no place in the needs for a finished surgeon.

There are no illustrations but there are numerous charts, outlines, and indices which make quick reference available. This book should be made available to the house staff on any well-organized surgical service.

J. M. Stallworth, M. D.

ONE HUNDRED AND TWELFTH ANNUAL SESSION SOUTH CAROLINA MEDICAL ASSOCIATION

MAY 17, 18, 19, 1960

OCEAN FOREST HOTEL

MYRTLE BEACH, S. C.

HOUSE OF DELEGATES

Dr. William Weston, Jr., Presiding

ORDER OF BUSINESS: Tuesday, May 17, 2:30 P. M.

THE CHAIR: Will the South Carolina Medical Association delegates please be seated.

(The invocation was pronounced by Dr. J. Dechard Guess, of Greenville, S. C.)

May I have a report from the Credentials Committee, Dr. Robert L. Sanders?

DR. R. L. SANDERS: Dr. Weston, we have 67 delegates and 11 Past Presidents, and we have a quorum, sir.

THE CHAIR: Thank you very much.

At this time I would like for you to use the microphone. If you care to come up here you will have equal liberties. If you will pronounce your name and give your County Medical Society or if you are an independent past president, do likewise, so that we will know who is talking and if you will, please use the microphone. Now, the tables have been set up for those who are officially delegates and I will ask those of you who are attending as spectators to be seated behind the tables and remain in order.

I would like to introduce the Sergeant-at Arms Chairman, Dr. Barney Timmons, if he will stand at this time. (Dr. Timmons stood and was applauded) Thank you very much.

At this time, a man who needs no introduction, who has been on the council for many years and was your Chairman last year until his election as President-Elect, Dr. Joe Cain, of Mullins. (The convention rises and applauds as Dr. Cain goes to the rostrum.)

DR. JOSEPH P. CAIN, JR.: Members of the House of Delegates, this is an unexpected pleasure. I didn't realize that I was going to be even introduced until late Thursday night at which time any comments which I might make would be cheerfully set aside until next year and you would not have to worry about it. I want to thank Dr. Weston for introducing me at this time because I do have something I want to tell you and in so doing I must apologize to Dr. Weston because what I am going to tell you is the same thing that appeared in my President's Letter which appeared in the *Journal* which came out yesterday. The reason I want to apologize to Dr. Weston is that the *Journal* wasn't supposed to come out until next week and I find myself in the very embarrassing position of writing the President's Page for you all to read before I become president. So, for that I apologize to you and to Dr. Weston.

However, because I have been given this opportunity, and because some of you may have not read that yet, I would like very much to read to you what I had to say in that letter because I want you to know what I plan to do next year and I want to ask your cooperation. (Applause) (Reading from *Journal*)

"The beauty and the strength of a lasting edifice depends upon the quality of the material with which it is built. The presence of a defective block in the structure of a building mars its beauty and undermines its durability. Similarly, a strong, serviceable State Medical Association is dependent upon the interest and integrity of its components—the County Medical Societies. The South Carolina Medical Association must not look to the American Medical Association to do its thinking. Similarly, the physicians

whose county societies make up the South Carolina Medical Association, should not look to the state Association to tell them what to do. Actually, it has to be the other way around.

"The local county Society is the most important unit in the South Carolina Medical Association. It is only at this level that problems which affect the individual physician in his particular locality can be met with and discussed. If these problems can not be solved on the local level, they can be carried to the State Association where they will receive the benefit of the thinking of all the counties and, similarly, on to the American Medical Association if necessary.

"Often we have heard the question 'Why does the American Medical Association take such and such a stand, or why does the South Carolina Medical Association say so and so?' The answer, of course, is that the American Medical Association as such, does not take any stand. It is the majority vote of the delegates from the individual State Associations making up the American Medical Association, which determines its policy. Similarly, the South Carolina Medical Association takes no stand. The policies of the South Carolina Medical Association are those which are arrived at by majority vote of the delegates from the individual county societies.

"The County Society is allpowerful. No physician can belong to the South Carolina Medical Association, or the American Medical Association, without first having been elected a member of his local county society. The reason for this is clear—the local county society is in a better position to know and to judge the qualifications of a man who seeks membership in our medical organizations than any other party. Similarly, discipline must be taken on a local level. The South Carolina Medical Association has no right to expel a member unless that recommendation comes from the local county society. It is true that the South Carolina Medical Association has set up a mediation committee where complaints might be aired through an impartial board if the local society so desires. However, many local societies have their own mediation committees. The ethics of the profession, the public relations of all doctors in the State depend on how these things are handled at home.

"In the past few years the South Carolina Association has had occasion to call on the county units for help in the resolution of problems which have developed on a statewide basis. The fact that we have been successful in these efforts is proof of the power which lies in the county societies. Without the support of the individual county delegations, which support is directly in response to appeals by these local county societies, the problems which we have faced in the State Legislature would have been much more trying and in many cases we would not have succeeded.

"In taking over the job as President of the South Carolina Medical Association, I am deeply cognizant of the honor which has been bestowed upon me. No one realizes more than I do that I was not elected by a State organization as such, but by the membership itself—representing each county in the State.

"My purpose for the coming year is to be one of full cooperation with the county societies. My aim during the coming year will be to meet with each individual society during that time. When regular meetings are not convenient, it will be my endeavor to meet with the groups in informal breakfast, or luncheon gather-

ings as seems most suitable for a particular area. At these meetings I would hope that a full discussion of medical questions could be carried out and all questions answered and clarified. Clarification of idea means that stronger programs will develop. Many subjects come to mind about which there are always areas for discussion.

"Among them are:

- (1) Our Public Relations Program.
- (2) Civil Defense.
- (3) State Legislation concerning Osteopaths, Optometry Blood Banks, etc.
- (4) Blue Cross and Blue Shield.
- (5) Health Legislation for the Aged.
- (6) The Benevolent Aid Society for Indigent Physicians and their families.
- (7) Medicare.
- (8) The State Insurance Program.
- (9) Permanent home for the Association.

And many others.

"It is my desire to have each county in the state fully informed on all matters which pertain to the State Association as a whole, and I want to be fully informed on all of the problems which involve the local counties. In this way we can be of real service to each other.

"In closing, I would like you to remember: In so far as medical affairs are concerned, your local County Medical Meeting is the most important meeting that you can attend."

Thank you very much. (applause)

THE CHAIR: Thank you, Dr. Cain. Dr. Cain's remarks will be referred to the Reference Committee on Reports of Council and Officers, Dr. O. B. Mayer, Chairman.

I think at this time it might be called to your attention the reference committees on the green slate with the black outline written in white and where they are to meet. I hope a great many of you will attend the reference committees and ask questions and have things explained so that you will not do anything that is unwise.

The Reports of Council and Officers, Dr. O. B. Mayer is Chairman, Dr. H. W. Bigston, Barnwell; Dr. John T. Cuttino, Charleston; Dr. W. N. Cochran, Spartanburg; Dr. Martin M. Teague, Laurens. Are all these gentlemen here? Is Dr. Teague here?

DR. GOLDSMITH: Mr. President.

THE CHAIR: Dr. Goldsmith.

Dr. Thomas G. Goldsmith, Greenville: Mr. President I have a letter from Martin saying he would not be here at this meeting, it would be impossible for him to be present.

THE CHAIR: Dr. Goldsmith, may I ask if you are on a reference committee?

DR. GOLDSMITH: No, sir, I am not.

THE CHAIR: You are now. Dr. Goldsmith will take Dr. Teague's place.

Legislation and Public Relations, Dr. Frank C. Owens, Chairman, Dr. Norman O. Eaddy, Sumter; Dr. Michael Patton, Spartanburg, Dr. Asa M. Scarborough, Greenville; Dr. Richard W. Hanckel, Charleston. I think I have seen most of these men here, I think it probably should be the duty of the Chairman of these committees to see that their members are there and if they are not there if they will let me know I will be glad to appoint somebody.

The Reference Committee on the Reports of Council and Officers will meet in the North Ball Room; the Legislation & Public Relations Committee will meet in the South Ball Room.

Public & Industrial Health, Dr. R. L. Crawford, Chairman, Lancaster, Dr. L. G. Llewellyn, Lancaster; Dr. Perry T. Bates, Greenville, Dr. Harry C. Tiller, Georgetown; and Dr. R. Maxwell Anderson, Charles-

ton. Dr. Crawford, do you know whether your committee members are present?

DR. R. L. CRAWFORD: Dr. Llewellyn is supposed to be here, I don't know about the others.

THE CHAIR: If you find any that are not here let me know and I will appoint someone. That Reference Committee will meet in the TV Room.

Committee on Amendments to the Constitution and By-Laws, Dr. Wyman King, Chairman, Batesburg; Dr. Ben N. Miller, Columbia; Dr. H. R. Pratt-Thomas, Charleston; Dr. William Blanton, Chesnee; they will meet in the Private Dining Room. If any of you men know that these men are not here I would appreciate your telling the Chairman so that he can notify me, so that somebody can be put in to fill any vacancies. Insurance, Blue Cross, Blue Shield, Dr. Clay W. Evatt, Chairman, Charleston; Dr. George D. Johnson, Spartanburg; Dr. M. W. Cheatham, Columbia; Dr. Waddy G. Baroody, Jr., Florence; Dr. W. D. McNair, Aiken. The place of meeting of this committee will be announced later.

The Reference Committee on Miscellaneous Business, Dr. Charles R. May, Chairman, Bennettsville; Dr. P. L. LaBorde, Columbia; Dr. Victor Branford, Dillon; Dr. George G. Durst, Sullivan's Island; Dr. B. M. Montgomery, Newberry. That committee will meet in a suite and the number will be announced later.

DR. WYMAN KING, *Chairman*, Committee on Amendments to the Constitution & By-Laws: Mr. Chairman?

THE CHAIR: Dr. King.

DR. WYMAN KING: I am told that Dr. Pratt-Thomas is not here.

THE CHAIR: Dr. Pratt-Thomas? May I ask the Chairman of the Credentials Committee who is taking Dr. Pratt-Thomas' place?

DR. SANDERS: We don't have an alternate, sir.

THE CHAIR: Will Dr. Grier I. Linton, Charleston, fill the place of Dr. Pratt-Thomas on Dr. King's Committee.

DR. SANDERS, *Chairman* Credentials Committee: Mr. Chairman?

THE CHAIR: Dr. Sanders.

DR. SANDERS: Dr. R. Maxwell Anderson on Dr. Crawford's Committee, Public & Industrial Health, is not present, sir.

THE CHAIR: I think Dr. Halsted M. Stone, of Chester is here, I will ask Dr. Stone to act in Dr. Anderson's place. Are there any further corrections or additions to these committees.

DR. SANDERS: Dr. Victor Branford, of Dillon is not here, sir, and Dr. B. M. Montgomery, of Newberry, named to the Committee on Miscellaneous Business.

THE CHAIR: Who is acting in Dr. Branford's place?

DR. SANDERS: We do not have an alternate, no alternate is named, sir.

THE CHAIR: Is Dr. Hall from Oconee here?

DR. SANDERS: No, sir, he is not here.

THE CHAIR: Dr. Richard A. Steadman? (Dr. Steadman answered) Dr. Steadman if you are not on a reference committee, you are on one now, you will take the place of Dr. Victor Branford. The other is Dr. Montgomery? Who are the delegates from Newberry, does Dr. Montgomery have an alternate, Dr. Sanders?

DR. SANDERS: No, sir, no alternate, he is the only delegate on here.

THE CHAIR: Is Dr. Harold W. Moody from Spartanburg here? Dr. Moody, I will appoint you in the place of Dr. Montgomery. Does that complete the list?

At this time we will have the presentation of resolutions and recommendations.

RESOLUTION ON NATUROPATHY BILL

DR. JOSEPH P. CAIN, JR.: Mr. President?

THE CHAIR: Dr. Cain.

DR. CAIN: Mr. President, members of the House of Delegates, I have a resolution which I consider to be of utmost necessity that we make a decision concerning. So much so that when I read the resolution and move its adoption I will of necessity have to ask the unanimous consent of the House of Delegates because timing is of the essence, it can not wait until tomorrow if we are in accord with the resolution, therefore it can not be referred to reference committee.

This resolution is a resolution which is to be sent to the Governor of South Carolina concerning a bill which has just recently passed the General Assembly. This bill allows some of the naturopaths, who we outlawed several years ago, to come into practice again under the guise of osteopaths. We are asking the Governor to veto this bill. The following is a resolution which I would like the House of Delegates to act upon. (Reading)

"WHEREAS, under the Constitution of the State of South Carolina the State Board of Health is made up of the South Carolina Medical Association in its corporate capacity, along with the Controller General and the Attorney General of the State, and as such is the sole advisor to the State of South Carolina on matters pertaining to the public health and

WHEREAS, there has passed the General Assembly a bill, known as House Bill #2572, which tends to license as practitioners in the healing arts persons without due process of examination or determination of their qualifications therefor, and

WHEREAS, this represents a serious breach of trust insofar as the public health is concerned in bringing into being a practitioner of the healing arts by legislation rather than by qualification and as such is detrimental to the public welfare,

THEREFORE, the South Carolina Medical Association by unanimous vote of its House of Delegates and in its corporate capacity as a member of the State Board of Health, hereby petitions His Excellency Ernest F. Hollings, Governor of South Carolina to veto this bill as being inimicable to the public interest."

Mr. President, I move the adoption of this resolution.

THE CHAIR: Delegates, you have heard the motion, do I hear a second? (It was seconded by Dr. Macdonald and many others.) Is there any discussion?

DR. P. L. LaBORDE: (Recognized) Mr. President, I would deem it worth while that we send a copy of this resolution to the Attorney General, who would also be in sympathy with the context of it and if Dr. Cain is willing I would move that also be done.

DR. CAIN: I accept that amendment.

THE CHAIR: Dr. LaBorde spoke without going to the microphone, I could hear him, I don't know if all of you could, moves to amend the motion so that a copy of this resolution will be sent to the Attorney General, Mr. McLeod.

Now, this is a very important resolution, ladies and gentlemen, because it was the purpose to pass it for one man who was a delegate from Oconee County and when they had passed it, then another naturopath stepped into the field and it is just opening the door, it is a wedge and I think it ought to be stopped, *right now*.

(The question was called for.)

The question on the amendment, all those in favor of the amendment.

DR. J. H. GRESSETTE (Recognized by The Chair) Mr. President, I am from Orangeburg, and I represent the Eighth District. I think we should table the amendment. As it stands at the present time we are dealing with the Governor and advising him of something that has passed that we want him to veto, and I think we should deal straight away with the Governor for it is actually a political stand we are taking.

He will have to take a political stand on this and I think its effectiveness stands with our direct appeal to the Governor and I, therefore, move to table the amendment.

THE CHAIR: A motion to table the amendment has been made, is there a second? (The motion to table was seconded by Dr. Burnside, Columbia)

THE CHAIR: There is no discussion of a motion to table and the motion to table the amendment is now in order. All those in favor of tabling the amendment please signify by rising. (The majority rose) The motion to table the amendment has passed.

Now, the motion for the original resolution, if there is any further discussion I would be glad to have it at this time.

DR. THOS. G. GOLDSMITH: (Recognized by The Chair) Mr. President, I believe there was one word in there that should be changed. (Dr. Goldsmith spoke directly to Dr. Cain and then announced that it was correct)

THE CHAIR: The motion that has been read by Dr. Cain, duly seconded, discussed, is now called for, I would like to see a unanimous vote. All those in favor please stand. The Sergeant-at-Arms will please notice if there are any negative votes. Those opposed, please stand. (none stood) The motion is unanimously adopted, so it will not be necessary to send it through a reference committee, it will go direct to Governor Hollings. Thank you.

Are there any further resolutions?

DR. JAMES C. SHECUT, Orangeburg: (Recognized by the Chair:) I am Dr. Shecut from the Edisto Medical Society and we have a resolution which was adopted by the Edisto Medical Society which I would like to read for your consideration.

(Reading)

"Whereas: A large percentage of our patients now have health and accident insurance, which we wish to encourage; and

"Whereas: The many and varied forms are confusing and sometimes time consuming in completing; and

"Whereas: We wish to offer the best service to our patients in helping them obtain their insurance benefits, thereby encouraging them to obtain this security; and

"Whereas: We believe a standard form would benefit all concerned.

"Therefore be it resolved that: The Edisto Medical Society hereby requests and urges the South Carolina Medical Association to appoint a special committee to contact and work with a special committee from the Insurance Industry of South Carolina for the purpose of adopting standard forms, such as one adopted by the Health Insurance Council or a newly devised similar form. Signed by

John B. Rembert, M. D. Sec. of
the Edisto Medical Society.

I would like to put this before the House of Delegates and ask its acceptance, Mr. President.

THE CHAIR: Is there a second. (It was duly seconded. Dr. Shecut will you leave a copy of that with the stenographer.) Is there any discussion of this resolution? If not, I will refer that to the Committee on Insurance, Blue Cross, Blue Shield in Suite "A". (This resolution is attached to the original transcript of this record, marked "B".)

THE CHAIR: Any further resolution? (The Chair recognized Dr. Parker)

GREENVILLE SOCIETY MOTION

DR. THOMAS PARKER, Greenville: I am Dr. Tom Parker from Greenville and I have a resolution which was passed by the Greenville County Medical Society on the 3rd of May.

(Reading)

"WHEREAS, the preservation of the solvency of the United States Government is essential to the preservation of the free world from destruction by Communism; and

"WHEREAS, Senator Wallace F. Bennett (Republican, Utah) in his "Washington Round-up" of March 9, 1960 has shown that the federal government is presently committed to programs involving the fantastic sum of one trillion dollars by the year two thousand; and

"WHEREAS, this figure does not include the regular annual cost of government or national defense or many other ordinary governmental expenditures; and

"WHEREAS, many members of the Congress are constantly introducing legislation to provide for the expansion of federal activities into new fields of endeavor which expansion involves new federal expenditures; and

"WHEREAS, a government currently committed to a debt of one trillion dollars is in no position to incur additional indebtedness; now,

"THEREFORE, BE IT RESOLVED, by the Greenville County Medical Society this third day of May, 1960, that it petition the United States Congress to refrain from embarking upon new federal spending programs in any field whatsoever including federal aid to education, federal aid to state, and municipal governments, federal aid to various "needy" segments of the population, federal aid to foreign governments, and in particular federal practice of medicine, and

"BE IT FURTHER RESOLVED, that this Society request the Medical Association of South Carolina to adopt a similar resolution for presentation to the Congress, and that copies of the resolution be sent to the South Carolina Senators and Congressmen."

THE CHAIR: This resolution is referred to the Reference Committee on Legislation and Public relations.

GREENWOOD SOCIETY RESOLUTION ON FORAND BILL

THE CHAIR: Are there any further resolutions? (The Chair recognized Dr. George Dean Johnson.)

DR. GEORGE D. JOHNSON, Spartanburg: Mr. President, I am George Dean Johnson, I would like to submit this resolution. (Reading) Congratulations to the Greenwood Medical Society for its letter on Medical Care of the Aging to Mr. Forand.

"WHEREAS, the Greenwood Medical Society through Dr. E. L. Bates has so ably expressed the feeling of doctors in South Carolina and the nation on the subject of medical care of the elderly population, and

"WHEREAS, the letter may not have received the publicity it deserves, and

"WHEREAS, the Greenwood Medical Society and Dr. Bates, especially, have done all doctors a great service, now

"THEREFORE BE IT RESOLVED, that Dr. Bates and the Greenwood Medical Society are hereby congratulated and commended for their thoughtfulness, and

"BE IT FURTHER RESOLVED, that Dr. Waring try to make space for its publication in the *Journal of the South Carolina Medical Association* as soon as practicable and if a copy has not been sent to all congressmen and senators from South Carolina that one be sent."

THE CHAIR: This resolution is referred to the Committee on Legislation and Public Relations.

Are there any further resolutions?

(There were none)

At this time we will hear from the Woman's Auxiliary and the introduction of Officers and guests of the Woman's Auxiliary. If I could get Dr. Tom Pitts and Dr. Kenneth Lynch to help the ladies in I would appreciate it. (The entire convention rises as the ladies come to the rostrum.)

THE CHAIR: We are indeed honored by having the representatives of the Ladies Auxiliary and I am glad this is not a repetition of my trying to make the Ladies Auxiliary last year when I went through the storm called "Gracie" and she threw so many curves I never got there. I take great pleasure in introducing the present president of the Woman's Auxiliary Mrs. John G. Ramsbottom, from Spartanburg, Mrs. Ramsbottom. (Applause)

WOMAN'S AUXILIARY

MRS. JOHN G. RAMSBOTTOM: Dr. Weston, and Members of the House of Delegates, as President of the Woman's Auxiliary to the South Carolina Medical Association I proudly present our report for the year. We have had a splendid year, and each individual chairman has certainly done a superb job.

Contributions for AMEF this year have totaled \$1582.87 which is an increase of \$120.66 over last year's total; \$96.75 of this amount was contributed by our State Board at the Fall Executive Board Meeting. We had some excellent projects throughout the state such as fashion shows, barbecues, Doctors' Day celebrations, memorials, bake sales, dish towel sales, and selling of spices and vanilla. According to the membership, Horry, Pickens, Spartanburg and Richland will receive awards for highest per capita contribution—Spartanburg for the largest contribution, and Richland showing the greatest increase over last year.

Recruitment of both nurses and allied medical fields has always been one of South Carolina's outstanding state projects. There are over 30 paramedical or future nurses clubs in South Carolina with a membership of 700. The change from Nurse Recruitment to Paramedical Recruitment has had a good start in the State and I feel sure that all counties will participate soon. This year a wonderful program was planned for the Future Nurses Rally with close to 300 registrations to be held at Winthrop College in Rock Hill. It had to be cancelled due to the flu epidemic.

Safety held an important spot with many county auxiliaries this year. Thirteen of our 18 auxiliaries responded to the Safety Questionnaire mailed March 1, 1960. A film, "Devil Take Us" was shown successfully in five high schools. Over 3,000 viewed this film, 6,000 pamphlets on Digest of S. C. Safe Driving Rules and "New Point System for Traffic Law Violations" were given high school students and manufacturing employees. One auxiliary had a booth in the County Fair with Safety displays, posters, etc. One other auxiliary had a poison shadow box for display in hospital.

South Carolina has gone all out to carry out the three projects set up by our AMA president, Mrs. Frank Gastineau—#1 Community Service, #2 AMEF, #3 Legislation.

As far as Legislation goes, we have written 85 letters to our representatives, congressmen and senators urging support of our Jenkins-Keogh Bill and non-support of the Forand Bill. Other organizations contacted concerning these bills were Federated Clubs, Junior Leagues, Garden Clubs, Church Groups, and Book Clubs. One auxiliary had personal contact with two representatives and their wives. Vice-President Nixon received a telegram from our State Auxiliary. A resolution from the State Medical Auxiliary is on record opposing the Forand Bill.

Community Service, National's #1 project, was most outstanding in South Carolina. A total of 61,962 hours was spent in Community Service throughout the state with about one half of the membership reporting. I feel that if the entire membership had reported it would have certainly reached 100,000 hours. This work included United Fund, Cancer Drive, Polio Drive, Heart Drive, Girl Scouts, Salvation Army,

King's Daughters, Muscular Dystrophy, Family Service Association, PTA, Crippled Children, YMCA, YWCA, Tuberculosis, League of Women Voters, Mental Health, Nurse Recruitment, and in many capacities with the church.

During 1959-60 our membership increased from 825 members to 865, which is an increase of 40 members. We have 24 members at large and 3 deceased members.

County auxiliaries worked with Mental Health and Civil Defense during the year. Six counties helped with Mental Health Problems. During Mental Health week 18 auxiliary members registered guests at the S. C. State Hospital. Another auxiliary gave \$85.00 for the winning essay on Mental Health. All county auxiliaries reported cooperation with their local C.D. organization. Twelve auxiliary members reported having taken a course in Home Nursing and 96 reported as having taken courses in First Aid. Several of our members attended the National Security Seminar in Greenville.

We have a total of 150 subscriptions to National Bulletin from 17 counties.

I must mention some of our outstanding voluntary service and philanthropic work. Sample drugs are collected from doctors for use in out-patient clinics; children on the Pediatric Ward are read to weekly; auxiliary members serve as Gray Ladies as well as work in hospital snack bars. I feel that the most outstanding work along this line has been one county's training Future Nurse Club members as Nurse's Aids with auxiliary furnishing uniforms, sleeve bands, pins, and caps. There are 40 girls in this class. One auxiliary brought in \$2,790.00 in nickels and dimes by selling Easter lilies for the Crippled Children's Society.

Many activities took place to celebrate Doctors' Day such as coffee parties, AMEF donations, giving red carnations to the doctors, suppers, etc.

Fortunately I was able to accept every invitation received by county auxiliaries, and it was truly heart-warming to visit each one and see the various interests in different parts of the state. It is a year of my life that I shall always cherish.

I would like to report that five counties entered the Essay Contest. Greenwood and the Pee Dee area had second and third place state winners and Greenville County won 8th place nationally.

I wish to take this opportunity to tell each member of the House of Delegates that we hope that the Woman's Auxiliary will continue to serve you as well as we have served this year because we do feel that we have had a successful year and we appreciate your cooperation. It is our desire to represent your organization in the very best light possible because we do feel that the women represent the men in a sense. Thank you. (Applause)

THE CHAIR: Thank you Mrs. Ramsbottom. Mrs. Ramsbottom's report will be referred to the Committee on Miscellaneous Business if she will be so kind as to leave a copy of that with the stenographer. At this time the president-elect of the Woman's Auxiliary will make her appearance before us and we are delighted to have her. She is a fellow Columbian and I am delighted to introduce to you Mrs. George Smith of Columbia. (Applause)

MRS. GEORGE SMITH: It is with a great deal of pleasure that I am here this afternoon and I would like to renew our pledge of loyalty and support to your good organization and I would like to tell you that we will give you our utmost cooperation during the coming year and I would most of all like to say thank you for my very handsome escort down the aisle this afternoon. (Applause)

THE CHAIR: We appreciate the work the auxiliary is doing and especially the recruiting of the nurses in the allied fields.

At this time I will ask Dr. Clay Evatt, the Vice-President to take the Chair while I lend a few remarks and the other request is that you use the hand-microphone, as Dr. Johnson did. In that way you can face the audience except for these few people here on the rostrum.

DR. CLAY EVATT (Presiding): Dr. Weston.

PRESIDENT'S REPORT

DR. WM. WESTON, JR.: Mr. Chairman, members of the House of Delegates, this has been a year of service, I have not been idle and I hope something has been accomplished. I have here a list of the meetings I have attended as President of the South Carolina Medical Association for 1959-1960. What I am going to do is run down with certain dates and fill in if I think any remarks need to be filled in. It is not this many pages, it is just a little over two pages. (Reading)

Date:

1. May 27, 1959: National Foundation Meeting at Wade Hampton Hotel, Columbia.
2. May 27, 1959: Meeting with Hospital Group of South Carolina, trying to organize plans for substitute bill for the Forand Bill.
And you will unquestionably hear this mentioned on several occasions because as you know it has been successfully pigeonholed but we just don't know how long.
3. May 27, 1959: State Meeting of Civil Defense for Survival at Wade Hampton Hotel, Columbia.
4. June 6, 1959: Meeting of the American Medical Association in Atlantic City.
5. June 14, 1959: Meeting of Blue Cross-Blue Shield in Columbia.
6. June 23, 1959: Meeting of Committee on Scientific Program of S. C. Medical Association, Charleston.
7. July 10, 1959: Unveiling and Presentation of Portrait of Dr. Robert B. Durham at S. C. Baptist Hospital, Columbia.
8. July 14, 1959: Crippled Children Medical Advisory Committee, Columbia Hospital, Columbia.
9. July 15, 1959: Insurance Group, Wade Hampton Hotel, Columbia. I might say to my successor that the insurance companies certainly have a lot of advice to offer and you can take it or leave it but they want you to do for them what they ought to be doing for themselves.
10. July 22, 1959: Executive Committee Advisory Board, S. C. Commission on Children & Youth, Wade Hampton Office Bldg., Columbia.
11. August 12, 1959: Scientific Meeting attended at Self Memorial, Greenwood.
12. August 13, 1959: Meeting with Mr. M. L. Meadors at Columbia Hotel in connection with the Forand Bill and the Legislative Program in general of the A.M.A. One of the Field Representatives, Mr. Richard Nelson attended. Also Dr. Frank Owens.
13. August 18, 1959: Civil Defense Meeting, Columbia.
14. September 1, 1959: Medical Advisory Committee, Richland County National Foundation, YWCA, Columbia.
15. September 10, 1959: Address at Opening Exercises of S. C. Medical College, Baruch Auditorium, Charleston. I might say that I made the editorial page there by advising them to read the newspapers.
16. September 13, 1959: Meeting of Blue Cross & Blue Shield—Quarterly meeting of Board of Directors of S. C. Medical Care Plan, Columbia.
17. Sept. 21, 1959: Civil Defense Meeting, Flynn Hall, University of South Carolina.
18. Sept. 29, 1959: Address S. C. Medical Auxiliary, Spartanburg. And I want to thank Dr. John

Fleming for being there and taking my place, as I referred to this a few minutes ago when Gracie stopped me. I got there but I got there after the meeting.

19. Oct. 14, 1959: Greeting to the Board of Directors of the American Cancer Society at luncheon, Wade Hampton Hotel, Columbia.
20. Nov. 2, 1959: Crippled Children's Society of Richland County, Columbia.
21. Nov. 3, 1959: Medical Advisory Committee Meeting, Richland County Chapter National Foundation, Columbia.
22. Nov. 4, 1959: Founder's Day Symposium and Seminar, The Medical College of S. C., Charleston.
23. Nov. 17, 1959: State-wide Civil Defense Meeting at Jefferson Hotel, Columbia.
24. Nov. 18, 1959: Meeting at Fort Jackson (Armed Forces)—Senator Thurmond spoke.
25. Nov. 24, 1959: Addressed the Spartanburg County Medical Society.
26. Nov. 29, 1959: Delegate to American Medical Association in Dallas, Texas.
27. Dec. 4, 1959: Medical Advisory Committee of National Foundation, Columbia.
28. Dec. 13, 1959: Blue Cross - Blue Shield, Joint Meeting, Luncheon, Columbia.
29. Jan. 11, 1960: Meeting of the V.A. Hospital concerning the set-up of the A.M.A. Speaker, Columbia Medical Society, re: Progress in Medicine and Public Relations. Duties of a Delegate to the A.M.A.
30. Jan. 14, 1960: Marlboro Annual Meeting. Dr. Robert Bennett, guest speaker on physical medicine.
31. Feb. 24, 1960: Addressed Edisto Medical Society in Orangeburg.
32. Feb. 25, 1960: Second District Medical Society meeting. Brief discussion of reorganization, in Columbia. It had not met for four and a half years. (It was reorganized and I hope it will continue to function.)
33. Feb. 29, 1960: Coordinating Council of State Handicapped Children.
34. Feb. 29, 1960: Delegates to White House Conference, Trinity Church Parish House, Columbia.
35. Mar. 4, 1960: Medical Advisory Committee, National Foundation, YWCA, Columbia.
36. Mar. 8, 1960: Addressed S. C. Conference of Social Workers, Columbia. Some remarks I made there they didn't like. They wanted to have the government give over to these people just what the Forand measure wanted and I told them I thought we could take care of our own.
37. March 11, 1960: Meeting of the State Crippled Children Society—Easter Seal Campaign Luncheon, Columbia.
38. Mar. 16, 1960: S. C. Insurance Company, Palmetto Bldg., Columbia.
39. Mar. 21-22, 1960: Tri-State Medical Association meeting. Represented S. C. Medical Association. Mrs. Weston, Jr., was Chairman of Ladies Committee, the Auxiliary, and did an excellent job.
40. Mar. 23, 1960: Medical Council Meeting with Dr. Wyatt re Osteopathic Bill.
41. Mar. 26, 1960: White House Conference on Children & Youth (Mar. 27-April 1, in Washington, D. C.) This should be called the "Black House Conference" as far as I was concerned.
42. Apr. 5, 1960: S. C. Medical Representative Meeting re Osteopathic Bill—appeared before Senate Committee, Senator Dennis, Chairman.
43. Apr. 12, 1960: Meeting re Osteopathic Bill—Ap-

peared before Senate Judiciary Committee.

We appeared before that Committee, Devereau, at that time Dr. Cain and Dr. Owens, Mr. Meadors, and there was somebody else.

44. April 12, 1960: Addressed Charleston County Medical Society. I left that hearing in Columbia and went to Charleston to address the County Medical Society there and, of course, the next thing on the program was this, the state meeting. (Applause)

DR. EVATT: Dr. Weston, we thank you for this very wonderful report and you certainly have had an active year. You have had a full time job and we know that the society has already reaped and will reap a lot of benefit from your activities. You have truly been a good president.

This report will go to the Committee on Reports of Council and Officers. Thank you Dr. Weston.

DR. WESTON (Resumes the Chair): Thank you, Dr. Evatt. Dr. Sanders, Chairman of Credentials tells me that Dr. Victor Branford, Dillon, has reported in and Dr. Steadman had been appointed in his place. Now, if you want to be relieved, Dr. Steadman, why I will be glad to let Dr. Branford serve as originally appointed. (Dr. Steadman acquiesced.) Thank you sir. The next is the report of the Executive Secretary, Mr. M. L. Meadors.

MR. M. L. MEADORS: Dr. Weston, Members of the House of Delegates, guests, before I make my report I wonder if I may make a couple of brief announcements in connection with the meeting?

THE CHAIR: Yes, sir.

MR. MEADORS: The association has arranged with the hotel for the amount of the tips in the dining room, and this will cover chambermaid service, to be included on the daily rate at \$1.25 per person, so you will not be expected to leave tips in the dining room or with the maids, that will be all taken care of.

The other announcement is the hours for the meals, as agreed between the hotel and the association: Breakfast 7:30 to 9:00; lunch 12:30 to 2:00; and dinner from 7:30 to 9:00 in the evenings. The luncheon and the banquet are included in the price of your daily rate for those who are registered in the hotel. Only non-registered guests of the hotel will be required to buy tickets for the alumni luncheon and the banquet on Thursday evening.

REPORT OF EXECUTIVE SECRETARY

Now, for my annual report. (Mr. Meadors reading) "Continued steady growth in membership and expansion of its activities have marked the progress of your Association during the past year.

The total membership for 1959 stood at 1482, including 1259 who have paid their dues and 152 honorary members, exempt from dues because of more than 40 years continuous membership. Twelve hundred thirty-three of our members were also dues-paying members of the American Medical Association, in addition to quite a number enjoying honorary status there, because they have passed the age of 70.

So far this year, a total of 922 have paid annual dues for 1960 to the State organization and 897 to A.M.A. This number is slightly under that for the same period last year.

As evidence of the continued growth, 20 new members have been enrolled to date in 1960.

A total of \$7178.00 was contributed by members of the Association to the American Medical Education Foundation Fund by a total of 670 contributors. Thus approximately 50% of the membership followed the recommendation embodied in the by-law adopted by the House a few years ago, for the payment of \$10.00 per member to A.M.E.F.

From the amount of the regular dues, the sum of \$6,210, representing \$5.00 per member, was trans-

ferred during 1959 to the Permanent Home Fund, representing \$5.00 for each member who paid during that year.

The general work of the office has progressed along the usual lines but has increased materially, following the pattern which has obtained consistently almost every year. We will not bore you with the repetition of an account of activities which follow the usual routine, and which you have heard in annual reports from time to time but will mention briefly those items which are a bit unusual.

Late in 1958 some of the radiologists in Spartanburg brought a proceeding against the Trustees of the Spartanburg General Hospital to obtain a declaratory judgment restraining the trustees from enforcing certain regulations which had been adopted for the operation of the Radiology Department. The trustees filed a demurrer which was upheld by the Circuit Court which ruled in effect that there was no justiciable controversy between the parties requiring the judgment of the Court at that time. The radiologists appealed, and pursuant to a resolution adopted by the Spartanburg County Medical Society, requesting the Association to intervene as a friend of the Court, Council directed that necessary steps be taken toward that end. Accordingly, a petition was filed in the Supreme Court at the December term, for permission to intervene *amicus curiae* and this was granted. We then prepared a rather lengthy brief citing authorities from many jurisdictions throughout the country. The argument was devoted principally to two points: (1) that the action of the trustees involved discrimination against the radiologists; and (2) that through such action the hospital was engaged in the corporate practice of medicine.

The appeal was argued by attorneys for the radiologists and the hospitals at the April term of the Supreme Court and a decision has not yet been rendered.

We have been concerned with several pieces of legislation proposed in the General Assembly this year and all the results were favorable. The proposal of chief interest was one to amend the law governing the practice of osteopathy. A very lengthy bill, this would have extended to osteopaths complete authority in all types of practice equal to that now enjoyed by doctors of medicine, without at the same time requiring of them adequate professional education and training in schools approved for the medical profession. The effect of the bill would have been to completely rewrite the medical practice act and dispense with all distinction between doctors of osteopathy and doctors of medicine. In view of its far-reaching implications, the bill actually never had any chance of success in that form. There are only a few osteopaths in the State and we are sure that they would have been quite satisfied to settle for some small extension of their present privileges. This, however, would have been only the first step and the Council and Legislative Committee directed that the bill be opposed *in toto*. This was done. At the request of the osteopaths, a public hearing was held before the Senate Committee on Medical Affairs, at which our side was ably presented by several of the Association's officials. The bill was never reported out by the Committee.

A bill introduced last year for the purpose of altering somewhat the licensing of chiropodists, contained desirable features but also it omitted certain restrictions included in the present statute. For that reason, it was necessary for us to ask that the bill be held up. This year, following several conferences with the representatives of the chiropodists, we worked out an agreement whereby the deleted provisions were fully restored and the provisions for improving the standards and qualifications were included, and the

bill was finally passed in form thoroughly agreeable to the Medical Association.

Representative Mitchell from Oconee County introduced one or two additional bills seeking to be relicensed to practice naturopathy. None was reported by the Committee but in the final days of the session, he succeeded in having the Committee approve a proposal to have him licensed as an osteopath. We took no action in connection with this bill one way or the other, and it achieved final passage on the last day of the session. What its fate will be at the hands of the Governor or in the Courts, if it should ever be tested, remains to be seen.

From time to time throughout the whole of the past year and for two or three months this spring, our attention was devoted almost continuously to work in connection with the Forand Bill. In Company with Mr. Richard Nelson of the Field Staff of A.M.A. last August, we visited each Congressional District in the State and conferred at pre-arranged meetings with legislative key doctors in each district, discussing the problem posed by the Forand Bill and plans to defeat it. Along with Dr. Bachman Smith and Dr. William Perry of Council, we attended in November a meeting in St. Louis, called and arranged by the American Medical Association for the purpose of considering the same subject. One of the projects, plans for which were fully outlined and discussed, was the Southeastern Regional Conference on the Care of the Aging held in Atlanta in March of this year. We assisted in procuring South Carolina participants on the program and attended the meeting, along with Dr. R. L. Crawford and Dr. J. P. Cain, Jr., and Dr. J. I. Waring, in March.

Assistance was also given Dr. Crawford and Dr. W. N. Cochran in perfecting organization of the State Joint Council on the care of the Aging. This Council, of which Dr. Cochran is Chairman, is now active and with the cooperation of the members of the Association, can contribute materially to working out improved voluntary plans for the health care of the aging population.

Along this same general line and related to the same subject, we attended in April a conference arranged in Chicago by the A.M.A. in preparation for the White House Conference on Aging to be held in January, 1961. Although effort was made to secure doctor representation at this meeting, those contacted were unable to attend and we served as the only representative of the State Association, at this meeting.

We conferred at length with the Executive Director of the Legislative Committee on Aging, established by resolution of the General Assembly in 1959, with a view to cooperation and securing doctor representation at the State Conference on Aging which will probably be held in July and, likewise, on the delegation from South Carolina to the White House Conference in January.

Numerous letters have been written and telephone calls made to promote letter-writing campaigns and personal contacts with congressmen at what appeared to be critical moments in the campaign against Forand type legislation.

We arranged the program for the Fourth Annual County Societies' Officers' Conference in Columbia in February. This was well received but the attendance was far less than it should have been.

Three additional insurance programs have been put into effect for members of the Association this year. We have been called on to cooperate in one way or another and have lent assistance whenever possible in connection with the institution of each of these programs.

The business administration of the Journal has required an increasing amount of time and attention

from our office. On the necessary retirement of Mrs. Claude Watson, who formerly handled the advertising, we assumed the additional work in this connection without the employment of extra personnel, and the business of the Journal has continued to increase and prosper, accounting for a total gross revenue from this source during 1959 in excess of \$54,000.00. Printing and engraving costs continued to increase rapidly so that, of course, the greater portion of this amount was expended in producing the Journal, but the revenue was sufficient still to leave a very nice profit from this source in the general fund. We have prepared and mailed from the office in Florence, 7 or 8 Newsletters to the membership, and these are being continued generally on a monthly basis with the probable exception of the mid-summer months. We also assisted the Woman's Auxiliary in the publication of two bulletins of that organization, the most recent one having just come from the press. We have had throughout the year the sympathetic interest and cooperation of Dr. Charles N. Wyatt, Chairman of Council, Dr. J. Howard Stokes, Treasurer of the Association, with whom the work of our office is closely connected; Dr. Robert Wilson, Secretary, and Dr. William Weston, Jr., President, who has kindly kept us well-informed as to the activities of his office through copies of much of his correspondence.

The past year has been a full and successful one. With continuation of the present policies, there is every prospect for continued advancement, and achievement for the organization.

Respectfully submitted,
M. L. Meadors."

(Applause)

THE CHAIR: Thank you very much, Mr. Meadors for that excellent report and that will be referred to the Committee on Reports of Council and Officers.

THE CHAIR: The next item is the report of the Secretary and I might say, in that connection, that he handed me a note and wanted to know would he get his 50¢ tip back from breakfast this morning (laughter) Dr. Robert Wilson.

REPORT OF THE SECRETARY

DR. ROBERT WILSON: Mr. President, Members of the House of Delegates, (reading)

"The activities of the South Carolina Medical Association for the past year have been largely of a type of quiet and watchful vigilance rather than of aggressive action. For this reason the Secretary has little of note to report.

"Routine activities in the internal affairs of the Association are largely handled by the Executive Secretary, and to him the Secretary is indebted for his efficient management of these details. One of the duties of the Secretary is to act as a liaison officer between the Governor's office and the Association, and appointments by the Governor to the various Boards, on nomination of the Association, is often somewhat confusing. However, at the moment these appointments seem to be clear and in good order.

"The Secretary acts as the Secretary of Council and most meetings have been attended. The Secretary also has charge of placement service for physicians in the state and all such inquiries have been properly acknowledged. However, for this service to be of much value the Secretary is dependent on information from physicians in all parts of the state regarding their professional needs, and opportunities, and no such service is of much value unless the Secretary is kept apprised of this type of data.

"I would like to remind the House of Delegates that it has been the policy of the South Carolina Medical Association to present a special award, a 50-year pin, to those members of the association who have been in

the practice of medicine for half a century. A supply of these is in the care of the Secretary. They are usually presented to the member by the Councilor at a regular county society meeting, and if you will let me know to whom such an award is due, I shall be glad to forward a pin to the Councilor.

"Again I would like to acknowledge my gratitude to the House of Delegates for the opportunity of having served you as Secretary for the past year, and for this privilege I thank you all." ((Applause))

THE CHAIR: Thank you, Dr. Wilson. That report will be referred to the Committee on Reports of Council and Officers.

THE CHAIR: Dr. Howard Stokes is the Treasurer and I have an extra handkerchief if he needs to weep. Dr. Stokes.

TREASURER'S REPORT

DR. J. HOWARD STOKES: Thank you, Mr. President, Fellow members of the House of Delegates, this is going to be short and, thank God, very sweet. In 1959 the Treasurer's Office handled collections a little in excess of \$128,000.00. Of this amount \$30,650.00 was remitted to the A.M.A. in member dues. Dues of the South Carolina Medical Association amounted to \$33,584.00. \$7,551.00 was collected for the American Medical Education Foundation; and revenue from advertising amounted to \$44,511.00, that being an all-time high and certainly a very practical compliment to our very fine editor, Joe Waring. The balance of the revenue was represented by Journal subscriptions, sale of the directory and miscellaneous income. The excess of revenue over expenses for the year amounted to \$16,350.83 resulting principally from the profit. The Association's investments were redistributed in accordance with direction of council at the last annual meeting. The sum of \$31,245.00 was invested in shares of Investors Mutual Incorporated; and \$13,553.00, representing at that time the amount of money in the Permanent Home Fund, in shares of Investors Stock Fund for its total investment of \$45,798. \$10,000.00 was left on deposit in the Peoples' Federal Savings & Loan Association. Our total investments now \$52,813.98 plus the excess of \$16,350.00. Thank you. (Applause)

THE CHAIR: Thank you, Dr. Stokes. The Treasurer's report will be referred to the Committee on Reports of Council & Officers.

South Carolina Medical Association Florence, South Carolina Balance Sheet

December 31, 1959

Assets	
<i>Current Assets:</i>	
Petty Cash	\$ 205.00
Bank	24,096.50
Accounts Receivable	2,906.26
Total Current Assets	\$ 27,207.76
<i>Investments:</i>	
Peoples Federal Savings and Loan	10,175.00
Investors Mutual Fund	31,245.31
<i>Permanent Home Building Fund:</i>	
Investors Stock Fund	13,533.38 54,953.69
<i>Fixed Assets:</i>	
Furniture and Fixtures	7,465.30
<i>Other Assets:</i>	
Deposits	3.00
Total Assets	\$ 89,629.75

<i>Liabilities</i>	
<i>Current Liabilities:</i>	
Withholding Taxes	\$ 250.46
<i>Surplus</i>	
Balance	\$59,998.46
Excess of Revenue Over Expenses	29,380.83
Total Surplus	89,379.29
Total Liabilities and Surplus	\$ 89,629.75

We have examined the Treasurer's records of the South Carolina Medical Association for the year ending December 31, 1959.

We certify that in our opinion the above Balance Sheet and accompanying Statement of Revenue and Expenses set forth the financial position of the South Carolina Medical Association as at December 31, 1959, and the results of its operations for the period ended on that date.

Respectfully Submitted,
JAILETTE & BRUNSON
Public Accountants

South Carolina Medical Association
Florence, South Carolina
Statement of Revenue and Expenses
January 1, 1959 to December 31, 1959

<i>Revenue:</i>	
A. M. A. Dues	\$30,650.00
Membership Dues	33,584.00
Subscription Dues	3,861.00
A. M. E. F. Receipts	7,551.00
Advertising	44,511.64
<i>Interest Earned:</i>	
Received	\$ 43.75
Accrued	114.97
Miscellaneous Income	783.96
Permanent Home Building Fund Receipts	6,240.00
Directory of Members	761.38
Gross Revenue	\$128,101.70

<i>Less-Expenses:</i>	
A. M. A. Conventions	1,696.45
Dues and Subscriptions	225.20
News Letter	159.44
Insurance	385.30
Office Supplies	1,214.93

<i>Journal:</i>	
Printing and Expense	25,984.38
Pro-Rated Salary	825.00
	26,809.38

<i>Salaries:</i>	
Editor	2,800.00
Executive Secretary and Counsel	10,000.00
Secretary and Others	7,909.00
	20,709.00
Postage	700.05
Telephone and Telegraph	2,111.15
Travel Expense	2,133.15
Audit and Legal Expense Public Relations	390.00
	1,202.13

Refunds and Transfers	969.50
Miscellaneous Expense	1,204.72
Taxes - Payroll	501.29
Directories	1,416.87
President's Office Expense	1,200.00
Secretary's Office Expense	117.42
Treasurer's Office Expense	125.00
Maternity Welfare Committee	200.00
Historical Committee	500.00
Rent	1,200.00

South Carolina Medical Association
Florence, South Carolina
Statement of Revenue and Expenses
January 1, 1959 to December 31, 1959

Committee on Infant and Child Health	\$ 71.87
Committee on Civil Defense	39.70
Woman's Auxiliary	985.90
Committee on Public Relations	841.42
A. M. A. Dues	30,650.00
A. M. E. F. Payments	761.00
Total	\$ 98,720.87
Excess of Revenue Over Expenses	\$ 29,380.83

South Carolina Medical Association
Florence, South Carolina
Statement of Receipts and Disbursements
January 1, 1959 to December 31, 1959

<i>Balance on Hand January 1, 1959:</i>	
Guaranty Bank and Trust Company	\$ 2,994.64
Bank of Florence	1,030.30
	\$ 4,024.94
<i>Receipts:</i>	
Statement of Revenue and Expenses	128,101.70
Withholding Taxes	2,824.15
Total	130,925.85
	134,950.79

<i>Less-Disbursements:</i>	
Expenses, Per Statement	98,720.87
Withholding Taxes	2,774.73
Accounts Receivable	1,166.51
Bank of Florence	
Account Converted to Stock Fund	1,030.30
Furniture and Fixtures	1,049.41
<i>Increase in Investments:</i>	
Permanent Home Building Fund	6,112.47
Total	110,854.29
Balance December 31, 1959	\$ 24,096.50

<i>Represented by:</i>	
Guaranty Bank and Trust Company	\$ 24,096.50

THE CHAIR: At this time we will have the pleasure of hearing the report of the Editor of the Journal, Dr. Joseph I. Waring.

EDITOR OF THE JOURNAL

DR. JOSEPH I. WARING: Mr. President, Members of the House (Reading) "During the past year the Journal has continued to prosper. Advertising has been adequate to carry costs, and there has been a gratifying increase in the number of papers submitted. Let me hasten to say that there is still a shortage, and while the editor can see a few months ahead in his material for publication, he cannot enjoy that snug and comfortable attitude with which editors of other State Journals survey an accumulation of papers for a year or more in advance. Therefore let me urge upon the members of the Association to flood the Journal office with contributions, even though it may be the unfortunately conscientious duty of the editor to decline some of them.

"No particular innovations have been made, other than to make some mild experimental changes with the type, and the manner of binding, and the addition of a nature-faking red palmetto tree on the front cover. The editor pines for comment and criticism. Lacking both, he might conclude that there is no serious objection to the present way in which the Journal is produced, but he does not concede that improvement is not desirable."

Mr. President, if I may continue with the report of the Public Relations activity, which has been in large measure tied in with the Journal?

THE CHAIR: The report of the Editor of the Journal will be referred to the Committee on Reports of Council & Officers.

THE CHAIR: Proceed, Dr. Waring.

REPORT OF PUBLIC RELATIONS ACTIVITY

DR. JOSEPH I. WARING: "If I have interpreted rightly the reason for the existence of the public relations program, it is based on a philosophy that the medical profession cannot afford nowadays to sit back comfortably and consider itself respected, loved, and trusted by the public as perhaps it could do in the past. There are many attacks on medicine, coming from many kinds of organizations, and we cannot sit idly and silently while sentiment is being built against us. It would seem to be not only proper but most politic that medicine make every effort to demonstrate to a questioning public the fact that the profession actually has at heart the general welfare of this public, and that it has many things to offer of which the public may not be aware or about which it may be confused. Therefore in a public relations program the profession is not only fulfilling its function of promoting health, but it is also creating, or preserving, if you will, a feeling in the mind of the public that medicine is more than a technical trade and that it has a real mission in its present state of organization.

"Last year at the instigation of Council, the House of Delegates approved the establishment of the public relations program and provided certain funds for its implementation. After a rather slow start due to the natural impediment of the summer season, we have proceeded with a program of television productions which has covered the greater part of the state and appears to have been received well in the areas included. The purpose of this program, known on the air as "House Call" has been to present sociological and economic problems which concern medicine and the public together. We have made no effort to present programs on technical subjects, and it is not our intention to invade that field unless we find some special indication.

"These 30-minute programs have been staged with a view to informality, and have included three or four, at the most five, physicians or people in related fields such as hospital administrators, educators, and so on, who provide the discussion which is as informal as possible and which takes place in a setting of the living room rather than in the less casual surroundings of an office or in any strict arrangement as a panel.

"We have asked physicians over the state to help with this program and they have been most kind in their response. Forty physicians and five hospital administrators have appeared on twelve panel programs, five in Charleston; three in Greenville; three in Columbia, and one in Florence. A presentation will appear soon in Spartanburg. The cost of air time has been donated by the television stations as a public service and our only cost has been a reasonable fee to our public relations agency for preparation of the details of the program and for some expense of travel. "We have endeavored to select subjects which would seem to be important to all of us as physicians or citizens, and to present them in such a way as to promote the feeling that the doctor can be helpful in other ways than those in which he pursues the routine of his practice.

"Our first discussion topic was aimed at combatting Forand-type legislation by presenting an objective picture of the problems of the aged. Since the first panel presentation, subjects covered on the shows have included information on the current cost of hospitalization, the dangers of food faddism, the menace of unlabeled poisons, and the opportunities afforded by medicine as a career. Among the topics scheduled for future discussion are the care and preservation of the American executive, mental health, and what is being done in South Carolina to bring fuller lives and better medical care to the aged. Other scripts will be prepared to complete a 12-month program.

"All of the source material for these programs has been taken from materials prepared by the American Medical Association. The basic scripts, which have been designed to stimulate panelists' minds rather than to be followed verbatim, have been prepared by our public relations agency with the advice of your representative.

"Using our television series as a stepping stone, we plan now to move into a series of individual addresses by physicians to the civic, fraternal and community organizations in their own towns and cities, which organizations appear to be constantly in need of good programs to fill luncheon sessions. These after-luncheon speaking engagements should afford us an excellent opportunity to get across our message—whether it concerns the inherent danger of a bill of the Forand type or the practical steps a modern businessman can take to avoid a peptic ulcer. Basically, what we want to show the public is that the physician is a keenly interested member of both the community and the human race.

"The success or failure of this new program will depend almost entirely upon local cooperation. The Association's public relations committee will provide the basic speech material and must promote the interest of the physicians in their communities who will deliver the addresses.

"The cost of the projects outlined about is quite nominal considering their range and scope. For an average of \$200 a month, our agency will script and schedule our television panels and as a starter will prepare and disseminate six different 20-minute speeches for the local speakers."

We do not have a full accounting of expenses to date but it was considerably less than the sum of money which had been set aside, partly because we did not

start as promptly as we had planned. I believe this program has had some valuable effect. We have had some pleasing comment locally and I understand in other areas in which it has been presented and I trust that the House will see fit to continue it. (Applause)

THE CHAIR: Thank you, Dr. Waring. This portion of your report will be referred to the Committee on Legislation and Public Relations, Dr. Frank C. Owens, Chairman.

We will now hear from the Chairman of Council, Dr. Charles N. Wyatt, of Greenville.

CHAIRMAN OF COUNCIL

DR. CHARLES N. WYATT: Mr. President, Members of the House of Delegates, because this report is so short I don't want you to get the idea that the affairs of Council are not multiple, and they have got to be met, but the fact is that most of what has transpired in Council meetings in the past year have been pretty well covered by the other reports that have preceded me. (Reading)

"I want to thank the members of Council for their diligence in attending the sessions and for their participation in the various matters that have come before us.

"The Council has had several meetings during the interim between the last state medical meeting, the first of which was in October 1959. One of the matters coming before us at that time was that of the budget which has been printed in *The Journal*.

"A delegation from the State Chamber of Commerce met with us in regards to the Fee Schedule as adopted last year and a committee of Council was appointed to work out with this committee the differences between the Chamber of Commerce and the Medical Association. This committee has functioned well and their report to Council revealed a lot of information to offset some of the complaints of the Chamber of Commerce committee. It is recommended by Council that the original committee, as appointed to consider the Fee Schedules, be continued and that this matter be reviewed by them.

"The usual number of bills were introduced in this session of the Legislature which have been followed, many of which required some action by Council and on some we served in an advisory capacity. The main subject calling for definite action on the part of Council was, of course, the introduction of the Osteopathic Bill allowing the osteopaths to practice medicine in this state and thus necessitating the revision of the whole Medical Practice Act. A hearing was held on this Bill on April 12, 1960 and officers of Council and the Chairman of the Legislative Committee appeared before the Medical Affairs Committee of the Senate in argument against such action.

"Council has considered during the past year the three insurance plans, that were worked out by the Insurance Committee in the House of Delegates, and endorsed these plans and recommend them to the membership of the association.

RECOMMENDATIONS:

"1) Council recommends to the House of Delegates that a benevolent fund be established for the benefit of the indigent members of the association and that a Board of Directors for such fund be elected by the House of Delegates according to the resolution as introduced, or which will be available for the reference committee to which this report is referred."

THE CHAIR: I will refer these as they come up, Dr. Wyatt.

Recommendation No. 1 is referred to Miscellaneous Business, Dr. Charles R. May, Chairman.

Dr. Wyatt continuing:

"2) Council recommends that the matter of the Fee Schedule adjustments be referred to the original committee for further study and for power to act."

Let me go into that just a minute in that we had a delegation from the State Chamber of Commerce meet with us in October protesting the high compensation rates in this state. Council at that time appointed a committee consisting of Dr. Joe Cain, Dr. R. L. Crawford, and Dr. Howard Stokes and these three men did an excellent job in delving into the matter of why, if any, our rates were higher than the other than our two adjoining states Georgia and North Carolina. They went into this thing quite thoroughly and came out with some very startling facts. They did a wonderful job in showing up they were not higher, actually, in our state but they were very much in line, the majority of them. However, we want to work with the State Chamber of Commerce, we have shown that attitude and they have been very cordial in receiving our committee but Council thinks this should be carried along further and therefore we are referring this matter with the information that the special committee of Council had to the original committee, who made their report last year, for further review and further study along with the Chamber of Commerce of South Carolina.

THE CHAIR: That recommendation will be referred to the Committee on Public & Industrial Health.

Dr. Wyatt continuing report:

"3) Council recommends the approval of the Keogh Bill and that the House of Delegates so notify their representatives in Congress to that effect."

That is the bill that is in the senate now for the self-employed and to replace your social security.

THE CHAIR: That recommendation will be referred to the Committee on Legislation & Public Relations.

Dr. Wyatt continuing report:

"4) Council recommends to the House of Delegates that help to the indigent through currently available channels be continued and that further extension of Social Security benefits be disapproved."

THE CHAIR: That recommendation will be referred to the committee on Insurance, Blue Cross, Blue Shield.

Dr. Wyatt continuing report:

"5) Council feels that the medical director of Civil Defense should be a continuing job and recommends that the plan as now prevails should be changed so that the president and the president-elect are relieved of this duty as Medical Director and Deputy Medical Director, respectively, and a member of this association be elected by Council to serve in this capacity."

THE CHAIR: That is referred to the Committee on Reports of Council & Officers.

DR. WYATT: The report is respectfully submitted. (Applause)

THE CHAIR: Thank you very much, Dr. Wyatt, especially for your long and active and continued service on the Council.

Dr. Johnson?

DR. JOHNSON: Mr. President, I think that has been pretty well covered in *The Journal* and at this time I don't care to add anything else. (Applause)

DR. EVATT (Presiding)

THE CHAIR: Dr. Weston, would you care to enlarge on your report?

REPORT OF DR. WESTON, AMA DELEGATE

DR. WESTON, JR.: Fellow members of the House of Delegates, this brief report. I feel sure all of you have read Dr. Johnson's report and this is a summary of what has happened at Atlantic City in June, the 8th and 12th, 1959. (Reading)

Report on Actions of The House of Delegates, A.M.A., June 8-12, 1959—Atlantic City.

"Among the major subjects brought up for action by the House of Delegates of the American Medical Association at the 108th Annual meeting held in Atlantic City were:

1. The report of the A.M.A. Commission on Medical Care Plans.
2. Relations between medicine and osteopathy.
3. The report of the Committee on Preparation for General Practice.
4. The issue of compulsory Social Security coverage for self-employed physician.

President Dwight D. Eisenhower addressed an audience of more than 5,000 at the inauguration of Dr. Louis M. Orr of Orlando, Florida, as the 113th president of the A.M.A. This was the first time that a President of the United States has addressed an A.M.A. annual or clinical meeting.

Dr. E. Vincent Askey of Los Angeles was named president-elect for the coming year. He will succeed Dr. Orr as president at the annual meeting in June 1960, in Miami Beach.

Dr. Michael E. DeBakey of Houston, Texas, chairman of the department of surgery at Baylor University College of Medicine, was the recipient of the 1959 Distinguished Service Award for his outstanding contributions in the field of cardiovascular surgery.

The recommendations of the Commission on Medical Care Plans included the following:

"Free choice of physician" is an important factor in the provision of good medical care. In order that the principle of 'free choice of physician' be maintained and be fully implemented, the medical profession should discharge more vigorously its self-imposed responsibility for assuring the competency of physicians' services and their provision at a cost which people can afford."

The House also strongly endorsed Recommendation B-11, which declares that "Those who receive medical care benefits as a result of collective bargaining should have the widest possible choice from among medical care plans for the provision of such care."

(House of Delegates—December 1-4, 1959, Dallas, Texas)

Major subjects acted on by the House of Delegates at the American Medical Association's 13th Clinical Meeting were:

1. Freedom of choice of physician.
2. Relations between physicians and hospitals.
3. A scholarship program for deserving medical students.
4. Relative value studies of medical services.

Dr. Chesley M. Martin of Elgin, Oklahoma was the 13th recipient of the annual award of General Practitioner of the Year, and was the first Oklahoman to be so honored. Dr. Martin was born a South Carolinian.

Dr. Louis M. Orr of Orlando, Florida, A.M.A. President, urged the nation's physicians to take a more active interest in the whole area of politics, public affairs, and community life. Dr. Orr also asked physicians and medical societies to do a more effective job of telling the positive story of medicine, stating that "if more people knew more about the things we support and encourage, they would listen to us much more carefully about those occasional things that we oppose."

The outstanding national leaders, Senator Lyndon B. Johnson and Speaker of the United States House of Representatives Sam Rayburn, spoke at the Tuesday morning sessions. Senator Johnson called for a "politics of unity" which will enable Americans to exert strength and determination in an effort to create a world in which all men can be free. Mr. Rayburn urged greater attention to the task of educating young people in the principles of American government and giving them a desire to perpetuate it.

A special study committee was approved which, when formed, was asked to:

1. Present a scholarship program, its development,

administration and the role of the A.M.A. in fulfilling it.

2. Ascertain the maximum to which medical schools could expand their student enrollment and maintain the high quality of medical education.

3. Ascertain what universities can support new medical schools with qualified students and sufficient clinical material for teaching—either on a two-year or a full four-year basis.

4. Investigate the securing of competent medical faculties.

5. Investigate financing of expansion of existing facilities and establishment of new medical schools.

6. Investigate financing of medical education in order to ascertain the most economical methods for procuring the highest quality of medical training.

7. Develop methods of recruiting well-qualified students to undertake the study of medicine.

8. Investigate the possibility of relaxing rigid geographical restrictions of medical schools for the admission of student.

This committee is to make its first report by June, 1960."

Mr. Chairman, may I call to your attention that Dr. Johnson's report is in the August 1959 edition of the *Journal of the South Carolina Medical Association* and in the March issue, I have them with me if the committee to whom you refer wishes it. (Applause)

THE CHAIR: Thank you very much, both of you. This will be referred to the Committee on the reports of Council & Officers.

I have been a member of this association for thirty-five (35) years and I have always been proud of our representatives of the A.M.A. South Carolina has always taken an active and prominent part in organized medicine in America. The second time the AMA met was in Charleston in 1848 and there, as some of you know is the Chair in Roper Hospital in which the President of the A.M.A. sat when presiding over that meeting.

Through the activities of Dr. Durst and the Chamber of Commerce we hope to have a booth at the A.M.A. down at Miami showing moving pictures of our gardens and lovely spots around Charleston, and we hope it will be well advertised in the A.M.A. Journal and that the doctors and their wives will stop by Charleston on the way to Miami or else on the way returning back from Miami. I am also especially proud and I know you are, of our Dr. Price who started out as a young fellow and represented us throughout the years as a delegate to the A.M.A., and has been an outstanding trustee for several years at the A.M.A., and we are very proud of our men who represent us and we thank you again for these reports.

DR. WESTON, JR. (Resumes the Chair):

We will now go to the committee reports.

We will hear a report from Dr. William H. Prioleau, Chairman of the Scientific Committee.

DR. WM. H. PRIOLEAU: This is the report of the Committee on the Scientific Program. There was a narrative report in an issue of the Journal concerning the activities of the program. The Scientific Program Committee further requests that the Association consider seriously a Cruise Convention. I thank you. (Applause)

THE CHAIR: Thank you, Dr. Prioleau, for a very excellent job, and Dr. Prioleau's report will be referred to the Committee on Miscellaneous Business.

In regard to what Dr. Evatt was talking about as to our contribution to the meeting in Miami, at Miami Beach, in June, the southeastern states have contributed each \$500 so that we will have a place for display down there and I have corresponded with the Secretary of the State Chamber of Commerce and the Development Board and we have had the promise

of Texize, 250 samples of Texize, and we have also the promise of some towels, which I don't think will be near enough, what they had promised, so I asked that they give more, I think it was 75 small towels, like hand towels. If any of you people who are delegates, ladies and gentlemen, know where we could contact mills or any manufacturing plant or beauty development areas, such as he referred to in Charleston, the Charleston Gardens and the pictures or anything of this kind would add to our public relations with the rest of the country will be welcome and Dr. Johnson and I will do our best to see that it is put up on a satisfactory display and Dr. Cain will also be there to help us. Dr. Frank Owens is going, too. Some of these committee reports have already been published in the Journal and if they have other things to add we will be glad to hear from them.

Committee Reports:

(1) Dr. Wyman King, Chairman of the Committee on Public Health.

DR. WYMAN KING: There is no additional report. THE CHAIR: Dr. King's Committee Report on Public Health published in the Journal will be referred to Legislation and Public Relations, Dr. Frank Owens, Chairman.

I think the Memorial Committee has a written report and we will hear from that in the morning, unless ruled otherwise.

(2) The Committee on National Health, Dr. Edward J. Dennis of Charleston, Chairman. That report is referred to the Committee on Insurance, Blue Cross, Blue Shield.

(3) Committee on Cancer. If no further report that will be referred to Public & Industrial Health.

(4) Committee on Legislation & Public Relations, Dr. Frank Owens, Chairman.

COMMITTEE ON LEGISLATION AND PUBLIC RELATIONS

DR. OWENS (Recognized) Mr. Chairman, I have a short supplemental report, if I may give it.

Most of this report was in the Journal but last year the House of Delegates upon recommendation of the State Board of Medical Examiners passed a resolution for re-registration of physicians every two years and in accordance with that the Committee on Legislation was asked to draw up a proposed bill to be presented to the legislature to put into effect and here is the proposed bill which, of course, will be revised. (Reading)

Reregistration

"Every person heretofore or hereafter licensed to practice medicine and surgery by the State Board of Medical Examiners shall, during the month of July, 1961 and during the month of January of every even numbered year thereafter, register with the Secretary-Treasurer of said Board, his name, office and residence addresses, and such other information as the Board may deem necessary and shall pay a registration fee fixed by the Board but not to exceed five dollars (\$5.00). In the event a physician fails to register as herein provided the Board may at its discretion levy a penalty of an additional fee. Should a physician fail to register and pay the fees imposed, and should failure continue for a period of thirty days, the license of such physician may be suspended by the Board after due notice and hearing at the next regular meeting of the Board. Upon payment of all fees and penalties which may be due, the license of any such physician may, at the discretion of the Board, be reinstated."

So this is the proposed bill to go to the Legislature. I might say that this was sent over to Jack Meadors to look over and see if he feels this is in good legal form.

THE CHAIR: Thank you Dr. Owens, that report will be referred to the Committee on Amendments to the Constitution and By-Laws, Dr. Wyman King, Chairman, meeting in the private dining room.

(5) Committee on Infant and Child Health, Dr. Walter M. Hart, Florence, Chairman. This committee report has been published and it is referred to the



Dr. Cain, incoming President, and Dr. John Cuttino, incoming acting president of the Medical College.

Committee on Miscellaneous Business.

(6) Committee on Welfare and Rehabilitation, Dr. Ben N. Miller, Columbia, Chairman. Dr. Miller's report has been published and is referred to the Committee on Legislation & Public Relations, Dr. Frank C. Owens, Chairman.

(7) Committee on Liaison with Allied Professions, Dr. Henry C. Robertson, Chairman. This Committee's report has been published, and it is referred to the Committee on Miscellaneous Business.

(8) Committee on School Health—I am not sure whether this has been published or not, but I had the report, I don't think this one has been published, and I will give a copy of it to the secretary. It is referred to the Committee on Public & Industrial Health, Dr. R. L. Crawford, Chairman.

(8) Committee on Care of the Patient, Dr. Joseph H. Cutchin, Chairman.

DR. J. H. CUTCHIN: I haven't any report to make, and I did not publish anything.

(9) Advisory Committee to Woman's Auxiliary, Dr. R. L. Crawford.

DR. R. L. CRAWFORD: No further report, sir.

THE CHAIR: That report is referred to the Committee on Miscellaneous Business, Dr. Charles R. May, Chairman.

(10) Committee on Medical Education Foundation, Dr. Edwin Boyle, Chairman. That committee report has been published and it is referred to the Committee on Insurance, Blue Cross, Blue Shield.

(11) Committee on Medical and Hospital Insurance Contracts, that Report is referred to the Committee on Legislation and Public Relations, Dr. Owens, Chairman.

(12) Committee on Rural Health, Dr. John C. Buchanan, Winnsboro, Chairman. That report is referred to the Committee on Miscellaneous Business.

(13) Committee on Historical Medicine, Dr. Joseph I. Waring, Chairman. (There was no further report) That report is referred to the Committee on Amendments to the Constitution and By-Laws. We have to give some of these committees something to do.

(14) Committee on Civil Defense. On the list Dr. Wyatt is listed as Chairman and he has retired from that position and your president was selected by the Civil Defense authorities. I think I handed in a re-

port and that will be referred to the Committee on Miscellaneous Business.

(15) Medical Advisory Committee to the Crippled Children Society of South Carolina, Dr. J. I. Waring has made a written report, is there any further report, Dr. Waring?

DR. WARING: Nothing further.

THE CHAIR: That report is referred to the Committee on Insurance, Blue Cross, Blue Shield.

(16) Committee on Industrial Medicine, Dr. W. W. Edwards, Greenville County, Chairman. That report is referred to the Committee on Legislation and Public Relations, Dr. Frank C. Owens, Chairman.

(17) Committee on Coroners-Medical Examiner, Dr. Pratt-Thomas, Charleston, Chairman.

DR. PRATT-THOMAS: This report has not been published in the Journal because I did not want it to appear in print. (Laughter) "This committee has been inactive during the past year. It appears desirable that the committee be continued so that this important problem be kept before the members of the S. C. Medical Association until it becomes feasible to take progressive action."

THE CHAIR: That report is referred to the Committee on Miscellaneous Business.

(18) Committee on Certification of Psychologists, Dr. Joe E. Freed of Columbia, Chairman. This report was published and that will be referred to the Committee on Amendments to the Constitution and By-Laws.

SPECIAL COMMITTEES:

THE CHAIR: Now, there are special committees.

(1) Fee Schedule Committee, Dr. W. W. Edwards, Dr. F. C. Owens, Dr. John Seigling and Dr. George Bunch, is there any report from that committee? We had a discussion about it in Council this morning, I think that would be included on the report of Dr. Wyatt, so we will refer that to the reference committee on Reports of Council & Officers.

(2) Medical Advisory Committee to the Selective Service, Dr. Frank C. Owens, Chairman.

SELECTIVE SERVICE

DR. FRANK C. OWENS: It might be of interest to some to know that State Selective Service Headquarters say that they do not know of any plans to draft any doctors any time soon and it has not been necessary for the last three years, I believe it is to actually call any doctor into service through the Selective Service Act. (Reading Report)

"Present Medical Selective Service Status.

1. All Reserve Officers in most specialties deferred for residences will be called.
2. There are twenty-one (21) doctors over twenty-six (26) who have been examined and are acceptable under Selective Service.
3. There are eighty-one (81) doctors now holding commissions who have not been called and who would be the first ones to be called.
4. The Armed Service still need doctors but those with Reserve commissions have so filled the supply the Selective Service have not called a doctor since 1957.
5. General Hersey recommends that doctors completing internship should seek deferment under the reserve deferment program or get a commission in the Reserves."

Signed: Frank C. Owens, Chairman

THE CHAIR: Thank you, Dr. Owens, that report will be referred to the Committee on Miscellaneous Business, Dr. Charles R. May, Chairman.

(3) The next is the report of the State Board of Medical Examiners, Dr. George R. Wilkinson, Greenville, Chairman.

MEDICAL EXAMINERS

DR. GEORGE R. WILKINSON: (Reading) The State Board of Medical Examiners of South Carolina Board Report for 1959. "The State Board of Medical Examiners met at its regular sessions on June 21, 22, 23 and December 8, 9; and called a meeting on May 12 (for endorsement).

"In 1959 the Board licensed 94 physicians by written examination and 41 physicians by endorsement of credentials. During the year 50 Temporary Permits were issued. There were 50 physicians certified to other states. Three duplicate licenses were issued.

"Compared with 1958, there were in 1959 forty-four (44) more physicians licensed and twenty-one (21) more physicians certified to other states.

"In 1959 seven (7) physicians were called before the Board on charges of narcotic addiction or alcoholism. One license was revoked.

"The Board is anxious to complete the business of biennial registration this year."

I would like to say this, some people have had the idea that the Board was in error in so far as it had the Attorney General to act as the attorney for the board. I would like to call this to your attention, which isn't in this report that the Board of Medical Examiners is an agency of the legislature and the only legal people we have to call are those appointed by the State of South Carolina and not by the Medical Association, so we have the Attorney General who has been extremely cordial whenever we meet and we have any plenary session of any sort they have from one or two lawyers there and we can get one within five minutes notice if we need one and they have given us wonderful service and cooperation and I think to use these gentlemen in this capacity furthers and improves our public relations.

Thank you. (Applause)

THE CHAIR: Thank you Dr. Wilkinson, that report will be referred to the Committee on Legislation & Public Relations, Dr. Frank C. Owens, Chairman.

(4) The report of the Executive Committee of the State Board of Health, Dr. W. R. Wallace.

STATE BOARD OF HEALTH

DR. W. R. WALLACE: Mr. President, Members of the South Carolina Medical Association House of Delegates, I simply want to report that since the written report was gotten up we have lost one of our very valued members of the Executive Committee Dr. Vivian F. Platt, who was a representative of the Pharmaceutical Association. Dr. Platt was a most zealous member and most attentive to his duties and I think had almost a hundred percent attendance, during his 20 years as a member of the Board and was very active in all of its activities and gave his counsel and advice which was always good. He was also a member of the water pollution board which requires that two members of the Executive Committee serve on this Board and he did an excellent work, also, in this. His successor will be elected at the coming meeting of the State Pharmaceutical Association in June.

I would like to say just one word about the report we submit. Years ago the Chairman tried to give a short resume of the activities of the State Board of Health and as the work of the Board and the responsibilities have multiplied so much—we feel that is no longer adequate, and so the report, as I say, is rather lengthy but we feel that every item is worthy of your consideration and we hope that you will take notice of it, we hope that you will file the *Journal* away so that any activity of the Board that you might happen to be interested in and want to know about you will know where to find it. And so, we submit to you a rather lengthy report because we feel that

every item in it is worthy of your consideration. (Applause)

THE CHAIR: Thank you Dr. Wallace, I read your report in the *Journal* and think it was exceedingly well done. I would like to refer this report to the Reference Committee on Public & Industrial Health, Dr. R. L. Crawford is Chairman and I would like Dr. Crawford to bring in a recommendation that we write Dr. Platt of his excellent services and send him a letter through the South Carolina Medical Association, if that is agreeable with him and his committee. UNFINISHED BUSINESS:

THE CHAIR: At this time we bring up unfinished business.

DR. KING (Recognized by The Chair) Dr. Pratt-Thomas is now in the room, would you like to reinstate him on his reference committee?

THE CHAIR: Dr. Pratt-Thomas, I am sure you are not having the students tardy on many occasions and when they are you forgive them, particularly if it is my son, so you had been replaced by an alternate and now I request that the alternate, Dr. Grier Linton withdraw so that you may serve on this Committee, that is the Reference Committee on Amendments to the Constitution and By-Laws, with Dr. King as Chairman.

DR. PRATT-THOMAS: Thank you, sir.

THE CHAIR: Is there any unfinished business? Is there any new business?

DR. R. L. CRAWFORD (Recognized): May I read a report of the Committee on Aging?

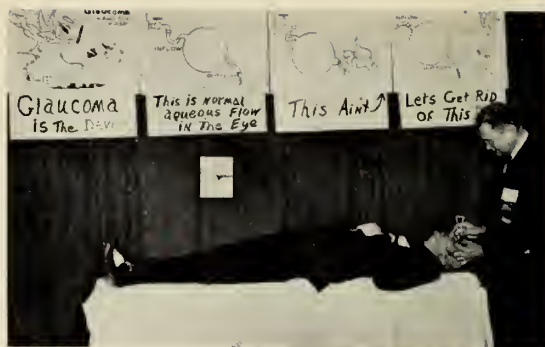
THE CHAIR: Just one minute. Dr. Thomas Parker is recognized.

ESSAY CONTEST

DR. THOMAS PARKER, Greenville: For the last several years I have been State Chairman of the A.A.P. Essay Contest and I would like to thank Council and the Association for supporting this contest, which I understand they will do again next year; and also the Woman's Auxiliary for what they have done. I will not be in charge of this contest next year because Dr. Donald Kilgo of Greenville will be in charge for the State of South Carolina. It was the opinion of our judges that we have had unusually good essays, that they are much better than they were in previous years and most of them were on the subject of the Advantages of the American Free Enterprise System, which we feel is to the advantage of the doctors for we feel some doctors have been selfish. But the national winner and also the state winner wrote on the Advantages of the American Free Enterprise System.

I would like to mention or to repeat that the contest will be conducted this year; that the response that it meets in different places depends upon whether we have one person who is willing to work to put it on. We hope we can get the English Departments or Social Studies Departments to put it on as a required essay in the schools. The A.A.S. has distributed thousands of essay kits and that gives you an idea of the size of the contest and I urge upon you—it is essential that we continue to educate the young people about the free enterprise system and the private practice of medicine because as you know we are under continuous attack and when the children get vaccinations at school and things of that kind they are prepared for socialized medicine and unless we educate them as to what is best they are going to take what comes easiest. And I urge you, as individuals, to try to get the essay contest put on in your county and I thank the South Carolina Medical Association and the Woman's Auxiliary again for what they have done in the past. (Applause)

THE CHAIR: Thank you, Dr. Parker. We in council have felt this a very important item and I would like



Dr. Stokes demonstrates at the Glaucoma exhibit.

to refer that to the Committee on Miscellaneous Business. We will hear Dr. Crawford.

COMMITTEE ON AGING

DR. CRAWFORD: This is the report of the Committee on Aging that was not printed in the *Journal*. We had difficulty in having our last meeting and this was written a few days ago. (Reading report)

"The first meeting of the Association's Committee on Aging was held on November 11, 1959, in the offices of Dr. O. B. Mayer, Columbia, South Carolina, with all members of the committee present. The work of the preceding committee headed by Dr. R. C. Smith of Conway was reviewed at this time.

"After general discussion of the foregoing and most recent developments, the committee adopted a course of action that should be followed, namely:

(1) Contact the State Board of Health of South Carolina to determine what statistics, if any, may be available with respect to the number of people in the State over 65 that are in need of nursing and health care who are unable to adequately provide the same from their own resources.

(2) Investigate the possibility of having data collected during the 1960 National Census reflecting the extent of the need for nursing and health care by persons over 65 years of age who are unable to provide the same from their own resources.

(3) Discuss with the Director of the Department of Public Welfare of South Carolina whether or not the possibility exists of utilizing funds available through the agency to provide low cost hospital and medical-surgical insurance for the indigent citizen over the age of 65 years.

(4) Contact and cooperate with the Governor's Committee on care of the Aging, offering our services and advice, if needed, especially to develop information to be presented at the White House Conference on Aging scheduled for January 1961. Also, suggesting to the Governor the possibility of his designating a specific week or day in the future to focus attention throughout the State upon the matter of health care of the aging and the responsibility of the citizens in this connection.

(5) Take necessary steps immediately needed to complete the organization begun May 6th, 1959, of a Joint Council on Health Care of the Aging. The Joint Council to be composed of members from the South Carolina Medical Association, South Carolina Dental Association, South Carolina Nursing Home Association, and the South Carolina Hospital Association. Wednesday afternoon, December 9th, 1959, was suggested as a tentative date for such a meeting.

It was felt by the Committee members that more could be done and accomplished through the Joint Council cooperating with the Governor's Committee. The meeting of the Joint Council was held at the

Columbia Hotel on December 9th, 1959 with Mr. Meadors and Doctors Waring and Crawford representing the Medical Association. At this meeting Dr. W. M. Cochran of Spartanburg was elected chairman of the Joint Council. From this meeting it was developed that there were 115,005 people sixty-five or over in the 1950 census in this state. The State Board of Health estimate in 1958 puts this estimate at 165,200. Figures from the Department of Public Welfare on November 30th, 1959, show 33,334 people in South Carolina sixty-five or over, who are drawing Public Welfare assistance. Life Insurance underwriters' figures on a nationwide level, as of June 30th, 1959, indicated fifty-five percent of the people of the United States who are over sixty-five years are dependent on others, twenty-six percent are still working, and twenty-three percent are independent.

"Three members of our committee attended the regional conference on Aging in Atlanta, Georgia, on March 7th and 8th, 1960. This was a very important and informative meeting arranged by the A.M.A. Council on Medical Service Committee on Aging in cooperation with the State Medical Associations of Alabama, Florida, Georgia, North Carolina, South Carolina and Tennessee. Many topics were discussed by experts in this field.

"This committee feels that we should continue to work with the Joint Committee on Aging and the Governor's Committee for the purpose of developing a comprehensive program of health care of our aging population. We are convinced that a program of this kind should be confined to the State and local level where it can be handled in an efficient manner.

"The following suggestions and recommendations have been made by our committee. We believe they are feasible and can be successfully carried out at the grass roots level provided proper support from the county medical societies and auxiliaries, along with the health departments, can be secured.

"They are (1) Education of the family groups as to their responsibility for the care of their aged relations; (2) developing a positive health care program in cooperation with the county health departments; (3) organizing visiting nurse and homemaker services; (4) providing low cost hospital and medical care insurance programs for the indigent through the Department of Public Welfare; (5) development of recreational programs for the aged at the local grass roots level with the help of the members of the auxiliary and other interested groups; (6) inducing employers to adopt a more sympathetic and realistic attitude toward providing as much employment as possible to able-bodied persons over sixty-five years, and (7) advising the community, as a whole, about their financial responsibility in the field of health care for the aging.

"We recommend that this committee be discharged, a permanent one appointed, and that membership on it should be staggered from one to three years.

"I would like to take this opportunity to thank the members of my committee for their valuable and diligent work during the year. It has been a great pleasure to work with them.

"This concludes our report, Mr. President.

Signed:

R. L. Crawford, M. D., Chairman

J. I. Waring, M. D.

O. B. Mayer, M. D.

M. L. Meadors

(Applause)

THE CHAIR: Thank you very much, Dr. Crawford. That report will be referred to the Committee on Insurance, Blue Cross, Blue Shield, Dr. Clay W. Evatt, Chairman.

Is there any further New Business?

I bring to your attention that Mr. Meadors has put

up there the suites where they will meet at 5:30 this afternoon. Insurance, Blue Cross, Blue Shield, Suite 137-138; and Miscellaneous Business, Suite 142 and 143.

THE CHAIR: Let's take this time, if there is no further New Business, to visit our people who are on the mezzanine and in the corridor who have displayed their goods and they are scientific, and we will meet or convene at 4:30. What time is it. (The Chair was apprised of the fact it was 5:00 o'clock, and there was laughter.)

I am sorry we will have to continue and have the Annual Meeting of the Corporation, The South Carolina Medical Care Plan.

SPECIAL ORDER— THE ANNUAL MEETING OF THE CORPORATION, THE SOUTH CAROLINA MEDICAL CARE PLAN.

DR. GEORGE D. JOHNSON, Presiding:

Gentlemen, this report will not take long. I ask you to be seated so that we can finish. You know last year we had to continue it over until the next morning.

As you know the House of Delegates is a corporated body of the South Carolina Medical Care Plan. I now declare the annual meeting of the South Carolina Medical Care Plan in order.

Since the proceedings of the last annual meeting of the corporation have been published in the *Journal of the South Carolina Medical Association* they will not be read again unless someone so requests. Hearing none, I shall proceed with the order of business. (Reading report)

"First, every doctor in South Carolina will be interested to know that our reserve has been growing steadily and more slowly since the increase payments to physicians last year. It is hoped that with continuing increase in enrollment larger payments may be made to physicians and increased benefits allowed for patients. All doctors are aware of the increased cost of operating an office and as soon as feasible increased payments will be made.

Our home office is operating more smoothly than ever before. It is still far from perfect but with every mistake made an improvement in processing a claim is sought for and I hope achieved. In the past month I had a claim returned to me. A request was made for a description and depth of the laceration. I cannot see how a laceration requiring only 3 sutures could possibly be very important. I suppose my charge of \$12.00 for 3 sutures and a tetanus toxoid booster was under scrutiny. I had another physician wonder why a lay person in the central office had asked for a pathological report in a certain case. This was done at the request of the medical director and I think the medical director's letter to the doctor surely put his mind at ease to the point that Blue Shield was not questioning the doctor's integrity but simply seeking more information.

I had another good friend write a letter blaming the Blue Shield for questioning the diagnosis of his own illness. The doctor didn't realize, nor did I, that all diagnoses are carefully checked during a waiting period in order to be sure that the condition did not exist at the time of underwriting. In this instance, as soon as the doctor's doctor wrote back payment was sent along to the hospital.

In other words most offenses are caused by a misunderstanding on the part of physicians as well as a failure on the part of the central office to make clear why more information in a particular case is needed. As I say, every time a misunderstanding is created an effort to avoid its repetition is earnestly made. I appreciate the correspondence of disgruntled physicians and I hope we have been able to explain why such

things have arisen. I hope these letters will not be necessary as time passes and the misunderstandings are cleared up.

Last year the House of Delegates sitting as co-operators of the S. C. Medical Care Plan approved the recommendation of the central professional committee and the council and endorsed our plan for caring for people over 65 years of age. This plan has been reported to Mr. Forand by the Medical Society of Greenwood through Dr. P. L. Bates. If you haven't read that letter I hope you have a chance to do so. In it Dr. Bates pointed out that for 18¢ a day Blue Cross and Blue Shield in South Carolina will care for most of the oldsters who get sick. He went on to point out that taxes to do the same thing through the Federal Government would cost much more. Our thanks go to the Greenwood Medical Society. Last year we stated that only about 3% of the population would be involved. A large group of subscribers were not expected. Our prognostications were correct. So far only about 1900 have signed up. We had to have this service for the same reason that the ultra liberals are pushing it, to wit, politics. Income from this segment of population will not amount to much but it was so very important to get it started.

As president of your Board of Directors, I must tell you that we have not been able to make much headway with the radiologists, or the anesthesiologists. The position of the radiologists is difficult. If his fee is reduced as much as a surgeon's it will cost him to take an x-ray of a subscriber. The anesthesiologists have strong arguments also. I still believe that some day a method of payment fair to the doctor, radiologists, and anesthesiologist, and also to the subscriber and to the plan can be worked out. Certainly, we shall continue to do our best to bring this about. I believe that doctors of good will working for a common end can certainly arrive at a reasonable compromise.

The regional committees that were announced last year have been called into action in two instances. One met earlier and I think corrections will be made without fanfare or publicity. That is much preferable to a lot of unnecessary and harmful talk. The other committee met last Thursday and I have not heard the results from it. I hope it will be equally as good. One striking result is the earnestness and fairness with which the members of the committee try to straighten out a problem. It also makes all the members of the committee more aware of the broad attitude that different doctors have towards insurance and their patients.

As of May 1 of this year there are 1133 participating physicians in South Carolina. This is an increase of 71 over last year and as nearly as we can tell represents about 81% of actively practicing physicians. We think this is a good percentage and we would like to see it increased.

Since the report last year there has been an increase of 6,355 new contracts or 10,000 new subscribers. The salesmen under Dave Dick have done an excellent job and are continuing to build up good prospects. My sincere thanks go to Mr. Sandow and his staff. On behalf of the Board I thank them. The Board especially the lay members deserve our appreciation and gratitude. Committees, especially the Central Professional Committee, have done their appointed duties well. I am grateful to the members of the Board for their cooperation and help. Then too the doctors of South Carolina have been very understanding and helpful. A few misunderstandings have arisen, but that is inevitable. Our aim continues to be the best possible medical care for the people of South Carolina. At the same time we must see that the attending physician is fairly paid for his ser-

vice. The S. C. Medical Care Plan is the doctor's plan, let's all support it and improve it.

The by-laws require that the Chairman of Council place in nomination candidates for positions on the board. Members of the Board retiring this year are: Dr. C. R. F. Baker, Mr. J. Harold Epting, Dr. J. Hal Jameson, Mr. Capers L. Peterson, Dr. William Prioleau, Dr. R. Cathcart Smith.

Dr. Baker requested that his name be withdrawn. He has been on the Board since Blue Shield was started. He has our sincere thanks, and he has added a great deal to our deliberations.

I would like to call on Dr. Wyatt to place in nomination the names of the candidates for the Board.

DR. CHAS. N. WYATT: Mr. President, and members of the corporation, the nominations as passed by Council this morning are Dr. Izard Josey, to replace Dr. C. R. F. Baker as you just heard he requested to be relieved; Mr. J. Harold Epting; Dr. J. Hal Jameson, of Easley, to succeed himself; and Mr. Capers L. Peterson; Dr. William Prioleau; Dr. Cathcart Smith; and of course Dr. Cain will replace Dr. Weston as an ex officio member as he takes over the chair as president.

There is one other ex officio member and that is if the Chairman of Council is replaced the new Chairman of the Council will become an ex officio member.

DR. JOHNSON: You have heard the nominations, none are allowed from the floor, the only thing you can do is vote for them or vote against them and we will put up some more. All those in favor of the nominations as given by Dr. Wyatt will say "aye", all opposed "No". (There were no negative votes) It is so ordered.

At this time I would like to call on Mr. William Sandow, Executive Director of our Blue Shield Plan for a few remarks.

MR. SANDOW: Thank you, Dr. Johnson, in view of the hour and in view of Dr. Johnson's rather complete report there is very little that I can add. I think the plan operationally is sound, and at least for the moment is financially sound. I am concerned at the rate in which we are going as far as enrollment is concerned. I think that unless we can expand rather rapidly both in terms of the number of people that we protect and also the scope of coverage which we offer and the amount of health care which we pre-pay for them, that we face very difficult and very serious times. It is my personal feeling that before the end of this session of the National Congress you will see passed some type of Forand-Type legislation. I think it is inevitable. I think that the reason that is going to happen is because we have all left a void in terms of a certain segment of the population being able to obtain health care. I think that once this happens the Government is going to be even more willing and certainly more able to step into any future voids which may exist or which currently exist. And so I think unless we can really move ahead and enroll more people under more coverage, and above all use as efficiently as possible the coverage which is in effect that we are going to be faced with the alternative of some type of a compulsory plan. As far as the distribution of health care is concerned, I think it is no longer a question as to whether or not it is going to be on a pre-paid basis, it is going to be pre-paid. I think the question that remains and the alternative that is before us is whether or not it is going to be pre-paid on a compulsory governmental system or whether it is going to be pre-paid on some kind of a voluntary system, which will not carry all the connotations that the Government program is going to. So, I think it is an utmost necessity that we work diligently, cooperate together, in trying to do the job which has to be done in order to prevent the Gov-

ernment from stepping in and doing it for us. (Applause)

DR. JOHNSON: I have a point that I would like to make, there are 23,000 Federal employees in South Carolina. There is a strong bid, not only by private companies but also by Blue Cross, Blue Shield for this group of subscribers. Your Council this morning approved a letter which will go out over the signature of our president urging these employees to subscribe to Blue Shield and also in the same letter there will be a signature by the President of the S. C. Hospital Association urging that they take Blue Cross. Anything that you can do locally, it will be appreciated.

DR. JOHNSON: Does anyone have any requests or suggestions for the good of the corporation? If not, I

declare this meeting closed and I will turn the meeting back to our President, Dr. Weston.

DR. WESTON: Thank you very much Dr. Johnson and Mr. Sandow. It doesn't refer to the gentlemen who are present but these people who knock Blue Cross and Blue Shield, I don't think understand it and if they just realize what Mr. Sandow has just said is perfectly true, unless we get voluntary insurance for these group of people we are going to be forced to pay for it. Now they can pay for it themselves but unless we do something in this connection I think we are really doomed and it is another way in socialized medicine.

If there is any further business please state it now. If not, the meeting is declared recessed until 9:30 Wednesday morning.

**MEETING RECESSED
MINUTES TO BE CONTINUED
IN THE NEXT ISSUE**



These notable characters are not really singing. Perhaps they are talking to themselves. They are obviously Dr. William Weston, Jr., president; Dr. George D. Johnson, delegate to the A. M. A.; and Dr. Joseph P. Cain, incoming president.

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HOME SAFETY NEWS

By: Earl W. Griffith

Maternal and Child Health Division
S. C. State Board of Health

CHLOROQUINE POISONING — The National Clearinghouse for Poison Control Centers has noticed a recent influx in fatal chloroquine poisoning in children since the induction of the drug in the treatment of rheumatoid arthritis and lupus erythematosus in the United States. To date, 3 fatal cases have been reported. The Washington, D. C. Poison Control Center noted the death of a 14-month-old boy after he swallowed between 1 and 2 grams of chloroquine phosphate, $2\frac{1}{2}$ to 5 times a single therapeutic dose. The death of a two-year-old boy was reported by the Connecticut State Poison Information Center after he had ingested an unknown amount of the drug (but not more than 3.5 grams), and the Boston Poison Information Center announced the fatality of a three-year-old-boy who had swallowed 0.75 or 1 gram, twice a single therapeutic dose.

The notable feature of these fatal cases was the rapidity with which death occurred after ingestion. All three children died within $2\frac{1}{2}$ hours. The fatality reported from Connecticut resulted 30 minutes after onset of toxic symptoms, following a generalized seizure and coma.

The drug is generally available as a diphosphate salt with a 60 percent base. The oral preparation is marketed as 0.125 and 0.25 gram tablets under the name, Aralen phosphate. The label bears the warning "keep out of the reach of children," however many drugs much less deadly than chloroquine are similarly labeled but are often left carelessly lying around the house within easy reach of the tots.

Some physicians in South Carolina are using Aralen phosphate in the treatment of patients with rheumatoid arthritis and lupus erythematosus. We feel obligated in warning the doctors of this hazard and recommending that a personal warning with each prescription, especially in families where there are children, supplement the one of the bottle label. It might just prevent a similar fatal poisoning of a child in this state.

At a recent two-day conference at the Royal College of Physicians the problems of occlusive arterial disease were thoroughly reviewed. In particular the relation of coronary-artery disease to sex, age, diet and the modern way of life was reviewed by experts in the field.

In general there was no great enthusiasm among those present for correcting the sex difference by eating of estrogens, nor for trying to eliminate lipids from their bodies by the aid of vegetable oils. Suggestions that permanent anticoagulant therapy, starting at some unspecified age, would be beneficial were received with murmurs of "rat poison," and although the idea of abandoning medicine in favor of farm

laboring appeared attractive, most of those present considered it was rather too late to contemplate such a radical change of occupation.

During the discussion a speaker asked whether any work had been done to correlate the incidence of coronary thrombosis with the number of miles the victims drove their motor cars each year. No figures were available, but it was agreed that the ever-increasing congestion on the roads must be considered an important factor in causing the kind of frustrations that are thought to precipitate thrombosis in predisposed persons.

—John Lister, M. D. in the New England J. Med. 262:189 (Jan. 28, 1960)

Psychosomatic problems in general practice, by W. T. Hendrix, M. D. (Spartanburg), (Tri-State M. J. 8:22-24, April 1960).

Few persons are so disturbed emotionally that they require psychiatric care. The family doctor not only sees them first, but also already knows the patient's job, wife, children, general pattern of life and treats several generations of his family.

Our problems: 1. Failure to keep psychosomatic problems in mind. 2. Lack of confidence to make a positive diagnosis. An increasing number of courses and articles are now available. 3. Failure of the doctor to stay as free of emotional problems as possible. Illness and stress at home, and being up half the night before engender anxiety. 4. Time. Extra time spent now may save more time on return visits.

The presence of "my doctor", a good history, carefully done physical, uncovering an emotional problem, working with the family, developing hobbies, correcting misconceptions about sex and heart trouble, and letting the patient ventilate constitute our minor psychotherapy.

Unconscious motives, dreams, fantasies are referred to the psychiatrist.

Tracheostomy for progressive weakness of the muscles of respiration. R. R. Bradham and O. R. Talbert (Charleston), Tri-State M. J. 8:11-14, May, 1960.

A group of cases have been treated at the Medical College Hospital during the past several years which demonstrated the important effect of tracheostomy on improving respiratory function in patients with marked weakness or paralysis of the muscles of respiration. Respiratory failure in these cases is insidious and must be recognized early before irreversible changes occur. Secretions collect in the lower respiratory passages because of the respiratory muscle weakness and the weakened or absent cough and swallowing reflexes. Adequate elimination of carbon dioxide and absorption of oxygen does not take place. Several vicious cycles occur because of the hypoxia and hypercapnia. Tracheostomy improves respiratory function by making possible the removal of secretions and aspirated material with facility and safety. Reduction in

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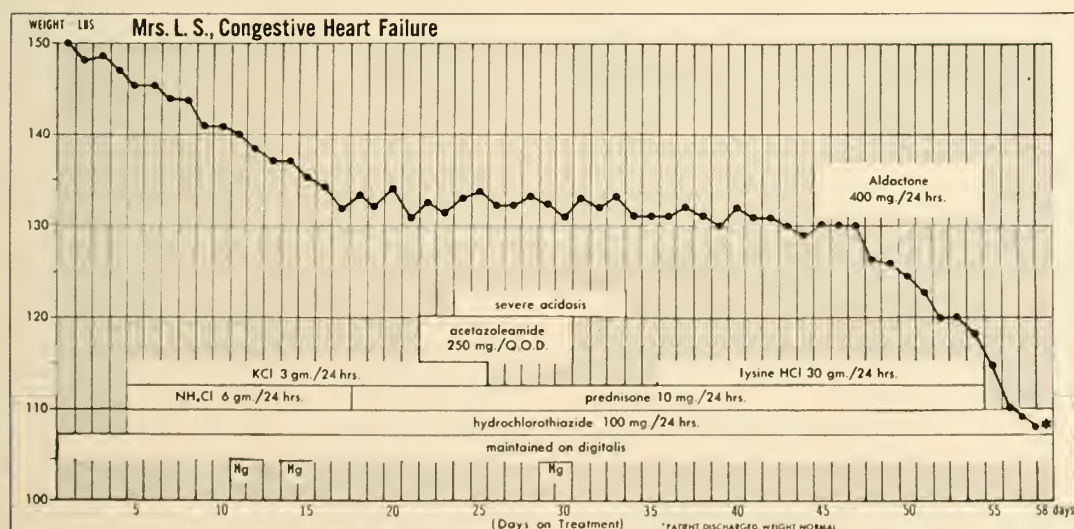
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respiratory work load is brought about by decreasing respiratory dead space and resistance to air flow. Important features of the technique and post-tracheostomy care are described.

BOOK REVIEWS

EDEMA—MECHANISMS AND MANAGEMENT. John H. Moyer, M. D. and Morton Fuchs, M. D. W. B. Saunders & Company, Philadelphia 1960. 835 pages. \$15.00.

This text is a compilation of the proceedings of a symposium on salt and water retention held at the Hahnemann Medical College in December of 1959. In their preface the authors state that as a result of the symposium it is hoped there will develop "a more comprehensive knowledge of the problem of edema and a greater understanding of the intricate physiopathology of the various clinical syndromes. Treatment then becomes a more coherent and organized effort in an area which is often fraught with a sense of frustration and futility." The book represents the opinion of many of the outstanding investigators in every aspect of the physiology and treatment of various edema syndromes. Newer concepts such as the counter current theory of the concentration of water by the collecting tubule of the kidney, the relation of the juxtaglomerular apparatus to salt feeding and salt deprivation, new ideas on the mechanism of action of the anti-diuretic hormone, considerations of the thirst mechanism, both primary and secondary hyperaldosteronism, the pathophysiology of the hyponatremic syndromes, are a sample of what is covered in the book. There is a section on the pharmacology and therapeutic use of the diuretics including the xanthines, the mercurials, triazine compounds, the thiazide derivatives, and the spiro lactones. There is detailed treatment of the role of sodium and electrolytes in the various hypertensive syndromes as well as in toxemia of pregnancy and premenstrual tension. The management of these syndromes is extensively discussed. Treatment of such entities as nephrosis and other edemas of renal origin, the edema of hepatic disease, and quite naturally, congestive heart failure are treated in extenso. Each section is followed by an appropriate up-to-date bibliography.

This is an excellent text for the student and for the person interested in learning more of current ideas of edema and its management. It is especially recommended for medical students, interns and residents, and those interested in broadening their knowledge of a wide area of medicine.

Cheves McC. Smythe, M. D.

KATE: THE JOURNAL OF A CONFEDERATE NURSE by Kate Cumming. Edited by Richard B. Harwell. Louisiana State University Press, Baton Rouge. Price; \$6.00.

Kate Cumming was one of the many dedicated women of the South who spent the war years in the capacity of volunteer nurse to the wounded Confederate soldiers who were harboured in hospitals in Alabama, Mississippi, Georgia and Tennessee. Her *Journal* reports her day by day hospital life, the workings of the Confederate hospital system, and her keen insight into the problems of the Confederate Medical Service. Of particular interest is her inclusive description of the remarkable system of mobile hospitals developed by Dr. S. H. Stout, Medical Director of Hospitals, Army of Tennessee.

This book was first published a few months after the close of the Civil War with the title *A Journal of Hospital Life in the Confederate Army of Tennessee*, and the immediacy of the events is readily felt by the reader. Copies of the original work are still to be found on the rare book market, but since price would make it prohibitive for the average reader, the present publication can be recommended highly. It is well edited for smooth continuity and easy reading.

C. A.

CLINICAL MANAGEMENT OF BEHAVIOR DISORDERS IN CHILDREN by Harry Bakwin & Ruth Morris Bakwin, 2nd edition, 1960. W. B. Saunders Co., Philadelphia.

After the lapse of seven years this excellent treatise has achieved its second edition. It is a very practical and simply presented exposition of the management of behavior disorders in children, and manages to maintain an interesting quality for reading. It carefully avoids the intricate and involved theories of the psychiatrist and keeps its practical considerations constantly in view.

This book can be recommended as one of the best in its field and one which should be extremely useful for the practitioner whether he is a pediatrician or a general man. It can be recommended wholeheartedly.

JIW

NINE MONTHS' READING, by Robert E. Hall, M. D. Doubleday & Company, Inc., Garden City, New York 1960. Price

Dr. Hall, of the Sloane Hospital for Women and Columbia Medical School, has done a remarkably good job in writing this book. It is a prenatal education for an intelligent woman. It covers the very basic practical considerations of types of practice, costs, hospitalization, partnerships, etc. It gives an excellent summary of the basic science of heredity, fetal development, and the Rh factor. There is an extremely good section on the explanation of early miscarriage, and the remainder of the book covering routine prenatal care, labor and delivery is extremely well done. Controversial subjects are fairly handled, although Dr. Hall expresses his own opinion

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THE ORGANIZATION MAN OF MEDICINE

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Changing Attitudes

Medical men boast that medicine is both a science and an art. The trend in modern practice is an accentuation of the science and an abandonment of the art. If the trend continues, there will be left ultimately a sorry, unsatisfying, poor imitation of traditional medical practice, with a vast overtone of commercialism and monetary grasping, and an emphasis on personal convenience and a subservience to desire for recreation.

However, although treatment of the whole man is claimed for modern medicine, the most important attribute of man, namely his power to experience emotional reactions, is being more and more neglected. There seems to have been a reaction from the former interest in so-called psychosomatic medicine. What a patient's emotional reactions are, what influence they have on his illness, and how they may be influenced therapeutically can be learned only through the prized personal relationship of doctor and patient. To develop such a relationship is time consuming and requires real sincere interest in the patient and in his problems. This aspect of medical practice is widely and rapidly deteriorating. As a result of this change in the attitude of doctors and in contrast with the fact that medicine as a science has advanced in public esteem, the individual physician has become the target of much petulant criticism and accusation, so that in a collective sense, he is no longer the "beloved physician."

The author deplores the decline of the practice of medicine as an art, and feels that "there might ultimately be left a sorry unsatisfying poor imitation of traditional medical practice" if science predominates the activities of the medical man and the art of medicine is left to wither. The importance of human and social relations is stressed and particularly it is pointed out that the teacher has a tremendous power to influence students' attitudes in these fields. There is a plea for the humanities in medicine, and a consideration of the influence of socialistic trends and some of the faults of group practice.

The author goes on to consider many of the current deficiencies of medical practice and pleads for a return to favor of the better ways of the older practitioner.

Is Medicine a Profession?

Medicine seems to be drifting away from the inherent qualities of a profession, and even more from those qualities which are referred to when it is spoken of as a learned profession. A profession is a vocation to which one is "called" by a deep desire to be of service to mankind. Too often medicine is chosen as an occupation after comparison with other occupations, because it seems to offer greater economic opulence, respectability, and opportunity for recreation. It seems to be taking on more and more the characteristics of a craft, in contrast to those of a learned profession.

There are, of course, many exceptions to this schedule of complaints. It may be true, as

Herbert Alden¹ recently stated, that we older doctors, "members of that uneasy middle generation who, forbidden by age to be modern and reluctant to be mellow, have a guilty feeling that we are in part responsible for some of the discomforts and some of the problems . . . in the practice of medicine." Hence, we are prone to criticize the modern trends.

Modern medicine differs greatly in its scope from the medicine of the days of unsubstantiated empiricism. Modern clinical medicine has applied and in many instances has improved the concepts of related sciences. The discoveries of chemistry, physics, pharmacology, physiology, and sanitary engineering have been applied to clinical problems, and they make medical practice more nearly scientific than ever before.

It is probable that sanitation, mosquito eradication, and economic betterment with improved nutrition have done more to prolong life than have improvements in clinical practice.

Importance of Human and Social Relations

So much more is required of a doctor than to know scientific medicine. As was once wisely said by a Spanish physician-philosopher, "The physician who knows only medicine does not know medicine." After a survey of half a century of medical progress, G. P. Berry, as quoted by Roy E. Trussell,² agreed that a broader concept of human nature and a more scientific understanding of the role of human environment on behavior (ecology) must be basic to professional training. Every student should be impressed with the possibilities of inducing iatrogenic disturbances and of the important medical problems they may produce. The doctor must know how to bring into the open the patient's anxieties and disturbing misconceptions. To do this without risk of deepening the anxiety, he must know the difference between interrogation and an interview.

Dr. Chesler,³ quoting Malleon, writes. "The triumphant progress of pathology and therapeutics (in the century after Pasteur) inevitably produced an apposite (or fitting) attitude in the minds of the doctors: both in research, in treatment, and prevention, the

lesion received more attention than the patient." She continued, "Modern doctors have to deal more with men than with cases—and with men and women whose harmonious course in life has been interrupted. Consequently human relations and social arrangements have become more important than medicine."

It is true already that except for illnesses incident to growing old, there are no major illnesses which do not involve emotional stress. That being true, there is great need by the young physician for training in human relations.

Teacher's Role in Students' Social Attitudes

The student's first training in handling patients comes from observing his clinical teachers in their relations with patients on the wards and in the clinics. The teacher necessarily expresses through his personality many assumptions and attitudes. The sensitivity of the student at his first ward round, the keen responsibility which he feels when first allowed to treat a patient, the care that he exercises not to frighten or to make more apprehensive the already apprehensive patient will soon give way to careless disregard of his sensibilities under the influence and example of a thoughtless or heartless teacher. The student soon recognizes the differences in attitude of the teacher toward the patient who is simply a case for instruction or a source of revenue, and the patient who is also a friend needing sympathy, encouragement, and kindly assistance.

Humanities in Medical Education

Dr. Alden¹ in an address to the Charleston County Medical Society discussed some speculations as to the basic causes of the less personal and at times rather callous and unsympathetic attitude of modern doctors. He is not alone in either his interrogations or in his suspicions. He asked, "Could it be that our scientific knowledge has so far out-distanced philosophy and religion that it has ceased to be a unifying force in medical education." He recalled that "The great founders of western culture of the eighteenth and nineteenth centuries were educated in institutions and homes in which classic works of culture revived from Greece and Rome and tintured with Chris-

tianity were the substance of their curriculum." It seems to him that more modern educators deny that it is either necessary or desirable to transmit this religious, classical culture. He said that "This has been called the greatest educational crime of our century against American youth, serving to deprive him of his classical heritage."

Similar attitudes are being voiced rather frequently by medical educators. Not so, however, I believe, by those educators who are responsible for preparation of students to enter medical school. Far too often, the pre-medical student in our liberal arts colleges is discouraged from taking courses in the humanities and is encouraged or required to take courses in science which will be repeated in medical school. If the required subjects constitute a difficult schedule, he is allowed to get his hours by taking "how to" courses which require little studious application.

Dr. Felix Marti-Ibanez⁴ referring to the positive value of classical culture said: "A life culturally enriched is the best way to attain ataxia . . . that which twenty-five centuries ago the physician Democritus defined as calm alertness and happiness of soul. In modern terms, this can be transmitted into self control and presence of mind in an emergency, akin to that supreme quality of the physician that Osler called *aequanimitas*."

The pressures of modern living and modern practice are causing very unpleasant effects upon our doctors. They display too much impatience, too much irritability, too little self control, and too little of the "milk of human kindness." To be a good physician, some one has said, one must be a good and kind man.

Influence of "Social Darwinism"

The old American formula for success, namely, hard work, thrift, and competitive struggle, is still believed in by doctors. That fact may be responsible for the harsh and mercenary accusations cast at doctors as a group. Alden¹ believes that we are inheritors of Herbert Spencer's "social Darwinism," or the survival of the socially fittest. "We believe, (said he) that we must compete with each other in any manner, right or wrong, in a struggle for existence and economic security.

If that be true, is it any wonder that medical men are unhappy men?"

Influence of Socialistic Trends

Economic and social changes, changes in the attitude of government toward health, making of it a social right like liberty, education, and pursuit of happiness, the increasing length of time and expenditure of money required before one may begin practice, the pressure of population increase, along with keen competition to get ahead in the economic rat race have tended to jade the nerves, to try the patience, and to weary the soul of the doctor. The wonder of it all is that regardless of mass antagonisms and accusations, trust continues in the monetary and intellectual honesty and the professional wisdom of the individual doctor—in "my doctor."

Faults of Group Practice

Much is being said about the economic wastefulness of individual practice of medicine and of the current vogue of patients bypassing the family doctor to consult a specialist of one's own choosing. Many mass purchasers of health care are demanding that it be furnished by medical groups, which contain specialists of various types. If the practice of medicine were an applied science only, if there were no personality factors involved, if the body were merely a machine, there can be no doubt that group practice would be less expensive and more efficient than solo practice by an individual doctor. But these provisos do not apply. Human illness, except for senescent changes, is almost always accompanied by or associated with emotional anxiety or stress. The emotional factors are frequently the most serious aspects of illness. They can be brought into the open only by the attainment of a rapport between the patient and the physician. There can be no rapport between the patient and a group of physicians. Further, because of division of effort and responsibility, no single member of a group can develop and maintain such a relationship with the patient. He cannot feel sole responsibility for the overall care and therapeutic direction of a case, nor can he develop in the patient a sense of dependency upon him.

Basis of Good Health Care

The kindly, sympathetic, understanding doctor, pecuniarily and professionally honest, who feels keenly responsible for the welfare of his patient, is the *sine qua non* of good health care. Scientific ability alone, without those personal qualities mentioned, cannot provide good medical care. True it is that many times the doctor will need and ask for consultation. However, he will not relinquish guidance and direction of his patient.

Tendency Toward Standardization

Medical practice by individual doctors who retain responsibility for their cases seems to be developing into a standardized pattern somewhat resembling group practice, with most of its faults and few of its virtues. This becomes evident when one examines the hospital order sheets referable to a group of somewhat similar cases treated by different doctors. The basic attitude of the several doctors toward their cases is reflected by clichés which are often heard. These are: "treat the patient and not the disease;" practice "good medicine;" "prevention is more important than cure;" it was necessary in order to "allay the patient's fears." These statements are heard so frequently that they strongly suggest a parrot-like repetition of what was heard when doctors were students. They certainly do not indicate any originality of thought, and an examination of the written orders frequently is less suggestive of originality.

The clinical approach to hospitalized patients and to patients referred to specialists because of real or fancied obscure conditions seems to reflect such a standardization. That approach reflects first an unwillingness to assume full responsibility for the patient's care; an unwillingness to trust one's own clinical judgment based upon a careful observation. Instead, there is haste to hospitalize the patient, even though the illness does not appear yet to be a serious one. Then the various tests are begun: x-ray studies of the chest, the upper gastrointestinal tract, the colon, and the gall bladder; an I. V. P., clinical laboratory tests, an E.C.G. If there is a backache, an x-ray study of the spine is ordered. If there is a headache, a study of the

skull and, perhaps, of the sinuses; if a joint aches, it must be "x-rayed."

"Treat the Patient, Not the Disease"

Because of this urge to make a quick and complete diagnostic survey, there is much unnecessary hospitalization. The costs of relatively minor illnesses run into three figures. The vast majority of the studies are negative (I am sure that many reports are not even examined.) Patients are receiving unnecessary radiation, with no record kept of the amounts. They are being taught to believe that it requires x-ray studies to make a diagnosis and that such studies provide infallible diagnoses.

The system does something to the doctor also. It involves him in a form of group practice, in which there is no joint consideration of the case by the members of the group; in which the other members of the group do not have an opportunity to examine either the history or the physical findings; in which too frequently there is no correlation of history, physical findings, symptoms, and laboratory findings. There are numerous separate fees and numerous separate reports and opinions. Too often the patient has recovered before the diagnostic work is completed, or else it has become evident that the basic condition is one of the various neuroses. It is interesting, too, to speculate upon just what determines the stopping point in the diagnostic survey of the "whole man." Why not routine blood sedimentation rate determinations, bone marrow examinations, blood sugar estimations, spinal fluid investigation, sigmoidoscopy, prostatic massage and examination, and other examinations that are frequently omitted from routine investigations? It is noticeable that examinations and tests which require personal effort and skills upon the part of the doctor or which are uncomfortable to the patient are those which are less frequently routinely made.

Is the doctor no longer willing to work at his job, to think, to make decisions to assume responsibility, to exercise expectancy when there is no urgent indication for urgency, to test therapeutic result, to support, encourage, and keep the patient reasonably reassured and to give nature a chance to cure, or to give the

patient and himself an opportunity to learn that the cure will be more unpleasant than the disease?

The most serious dereliction in the scientific care of the patient is failure to secure and record a careful and complete clinical case history. Dr. Marti-Ibanez¹ states it this way: "The most important medical document has always been the clinical case history, whether of unusual or of ordinary cases, that 'small change' of medicine which contributes the real capital of the physician's experience." An intern cannot write a good history of a complicated or obscure case. If he could, he should not be an intern. However, he should conscientiously do the best he can, in order to learn to do better. The taking of a history should be an interview rather than an interrogation. It is a form of therapeutics, for words are instruments of healing as well as of communication.

Students seem to have been taught more what to order and how to order and too little of why to order. A careful history and physical examination give important clues as to what and why to order.

Dr. Alden¹ rather bitterly criticizes the younger doctors. He believes that their faults arise from the tremendous pressures toward uncritical conformity. He says that, as a result, they are no longer interesting people. Instead, he finds them self-complacent, comfort-loving, unenterprising, and at times their smug attitude is coupled with colossal ignorance as well as lack of curiosity. They seem not to know that "normal" has a wide range.

There is increasing pressure for "good medical care" at the lowest possible cost. When that pressure is governmental or by organizations like the labor unions, one may say with considerable truth that the pressure is exerted by individuals or by groups of individuals who do not know what constitutes good care. They overlook or discount the value of art in medical care. There is also unorganized, individual pressure developing. There is widespread complaint of hospital bills, of drug bills, and of the fees of doctors. There is a prevailing belief that sickness insurance rates are too high.

Good Care at Reasonable Cost

Younger doctors beginning practice must share the responsibility with older men of trying to keep the costs down without compromising the quality of medical service. Efforts to keep down costs of illness and at the same time maintain the quality of care are not incompatible. Hospital utilization may be lowered, unnecessary and expensive laboratory examinations may be reduced, and duplication and unnecessary prolongation of treatment with expensive drugs may be discontinued, without effect upon the quality of treatment.

Attempts to lower the cost of good medical care does not necessarily involve the general establishment of group practices. Nor does it mean that individual practice should be of a standardized group pattern. Neither group practice nor standardization of practice in a group pattern constitutes great medicine. Either may and frequently does result in medical conclusions and practices for which no individual doctor assumes responsibility. Both lack the positive powers of individual thought. Both tend to deny rapport with the patient. Both lack the values that come from true consultation with a colleague.

Whether medical care be by a group or by a doctor who is prone to apply a standardized group pattern in his practice, there are involved in the care of a case multiple doctors, each with individual findings and interpretation of findings, and there is lacking in each instance a meeting of minds in discussion and in evaluation of the findings and in their interpretation and application to the case in point.

Individualism vs "Togetherness" and Standardization

The tremendous pressures toward conformity of pattern in practice, along with an unwillingness of doctors to assume personal whole responsibility; the idealistic desire to treat the "whole man" or, as it is frequently but erroneously expressed, to practice "good medicine;" the fear of delay in recognizing concurrent disease or abnormal conditions; an unwillingness to give nature a chance to heal; a failure to recognize the role of apprehension in causing symptoms; and an unwillingness to

attempt to reassure the apprehensive patient without a handful of negative laboratory reports of various kinds, all tend to produce a sense of "togetherness" by doctors, all tend to destroy their sense of individual responsibility, and all tend to make of them "organization men"—men all of whom have been cast in the same mold by the application of the same pressures. The doctor's pride in rugged individuality is rapidly disappearing, I believe. No longer does the average physician heed the exhortation of Dr. Edward L. Keys, as quoted by Alden:¹ "Fear not to give of time and enthusiasm and life itself to your profession. Let truth and fidelity and gentleness be the coin of your realm . . . The great physician of every tomorrow, like the great physician of yesterday, will be he who spends himself most in giving. It is returned to him a hundred fold in the affection and adoration of his fellow man."

Alden added: "Medicine is the all night vigil and the early morning call. It is the deep pleasure at allaying the fears in time of stress, and it is the always new and enduring wonderment of man to be able to withstand a beating from disease and accident and then come out well and whole. It is also the sad-

ness of the losing fight. It is the graceful way you save a life by your knowledge and dexterity, but let the credit go to others so that they may emulate both your abilities and your graciousness."

This is the kind of medicine which made doctors beloved, admired, and respected. It cannot be practiced in groups with division of responsibility. Nor can it be adapted to standardized conformity. It need not be exorbitantly expensive. It is foreign to the thinking and the feeling of the "organization man" who cannot do his own thinking and who cannot share himself with his patient. It does not conform to any standardized pattern, and it is devoid of any sense of security based on "togetherness." This is the medicine which makes doctors who are humble, yet proud of their profession, who are often tired but never too tired to go when called, who are often perplexed but who are never afraid.

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Endocrine therapy in general practice, by J. R. Sosnowski, M. D., (Charleston, S. C.) Tri-State Medical Journal. 8:5-8, April 1960.

Basic principles of endocrine therapy are: (1) stimulation of a hypo-functioning gland; (2) substitution for a hypo-functioning gland; (3) suppression of a hyper-functioning gland.

Gonadotrophin preparations can produce anti-hormone formation. Thyroid dosage should not be changed more frequently than monthly. Estrogen and progesterone to regulate menstrual disturbances should be given cyclically, always following estrogen with progesterone in the management of excessive bleeding. Androgen dosage should not exceed 300 mg. per month orally.

Diagnostic methods include basal temperature chart, vaginal cytology, and endometrial biopsy.

Amenorrhea often requires complete ovarian substitution. Excessive menstruation not requiring D & C may be treated with estrogen and progesterone, or else some of the recent potent progesterones. Threatened abortion not responding to bedrest and sedation should be given a trial of estrogen and progesterone, choosing a non-virilizing progesterone. Suppression of lactation can be accomplished with small doses of estrogen.

In treatment of menopausal symptoms, endocrine therapy should be reserved for last, and after exclusion of malignancy, and should be given cyclically.

In summary, endocrine therapy should invoke the basic principles of the physiology of the reproductive system.

MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

Pulmonary Embolism

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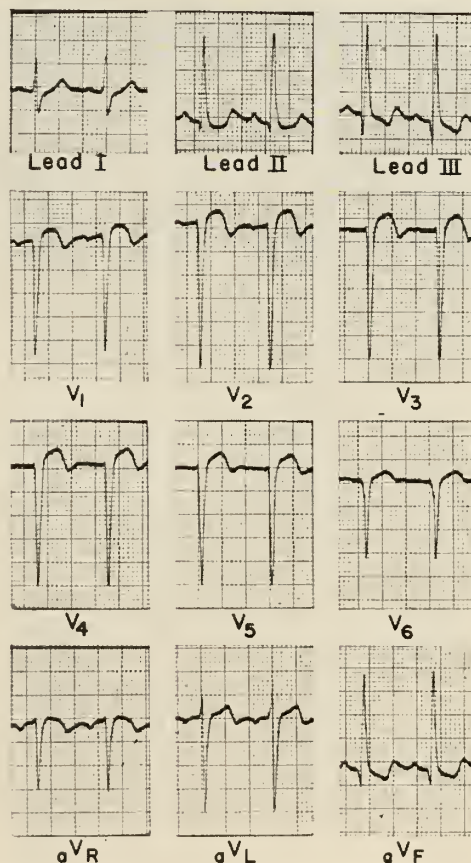
During the four years I have been writing this series I have sought among routine tracings, hospital files and colleagues around the state an electrocardiogram which might be called "typical" of pulmonary embolism. So frequently in these cases death ensues before a tracing can be recorded. Or if one is made the technical quality of it is often unsatisfactory due to the urgency of the situation, emergency measures for resuscitation or the patient's critical condition. On the other hand, ones recorded days or weeks later may fail to show the acute changes which are the most helpful in establishing the diagnosis.

Although most of the electrocardiograms of patients with acute pulmonary infarction show abnormalities of some sort, the full blown classical pattern is surprisingly rare. The following case, contributed by Dr. Solomon Zimmerman of the U. S. Veterans Administration Hospital, Columbia, South Carolina, is as representative as most.

Case Record—A 69-year-old man with a long history of hypertension underwent an above-the-knee amputation for arteriosclerosis obliterans with gangrene of the toes. Two days after the operation he complained of pain in the right lower chest. His blood pressure, previously on the order of 180/110, fell to shock levels and despite anticoagulant and intravenous nor-epinephrine therapy he died on the 5th postoperative day.

The electrocardiogram illustrated was made 24 hours before death. At that time a chest roentgenogram showed some haziness of the right lower lung field in addition to the moderate left ventricular enlargement noted on a preoperative film.

Autopsy diagnoses were: pulmonary embolism with infarcts in the bases of both lungs, pulmonary congestion and edema, and generalized arteriosclerosis. A long twisted embolus was found extending from the right ventricle straddling both pulmonary arteries and extending into the major branches of each. No site of origin of the embolus was found in a dissection of the inferior vena cava and iliac veins as far down as the femoral triangles. The heart was dilated, weighed 440 grams, and the coronary arteries were markedly sclerosed but not occluded. Because of the electro-



cardiogram a diligent search was made for any infarction of the myocardium but none was demonstrable.

Electrocardiogram—There is a regular sinus rhythm at a rate of 100 and normal AV conduction (P-R 0.16). Comparison of the R waves in aVL and aVF shows a more vertical axis than one would expect in a patient with long-standing hypertension. The Q waves in leads III and aVF are quite deep but their width of only 0.02 and the fact that there is an associated wide slurred S wave in lead I suggest that their origin is more likely positional than due to any infarction of the posterior or diaphragmatic wall. In the same leads the T waves are diphasic and apparently followed by U waves giving the appearance of prolongation of the Q-T interval which can be seen elsewhere to be about normal.

There is almost complete absence of R waves in all

precordial leads. While the S waves progressively diminish in amplitude to the left of V_2 , there is no commensurate increase in R waves which were present there in a preoperative tracing. This might be accounted for in part by extreme clockwise rotation of the heart shifting the transition zone toward the left—(note that the P wave is still inverted in the V_2 position)—and the left ventricle around toward the back but ordinarily in such rotation a Q-R deflection similar to that normally recorded over the back of the heart is likewise shifted around to show in aVR.

Elevations of S-T segments followed by inverted or diphasic T waves are present in precordial leads as far to the left as V_5 . The QRS is at the upper limit of normal as to width—0.10.

Discussion—If interpreted without reference to previous electrocardiograms or other clinical findings, this tracing is perhaps more indicative of anterior wall infarction than anything else. Certainly it is not diagnostic of pulmonary embolism but does display some suggestive features, notably the prominent S waves in I with Q waves in III, the inversion of T waves in the right precordial leads and the clockwise rotation. These are all the more significant since they were not present in the preoperative ECG. Substantiating this diagnosis ante mortem was the chest pain (which is often pleuritic in nature), the roentgenographic evidence of localized pulmonary pathology, and one of the most consistent manifestations of pulmonary embolism, a precipitate drop in blood pressure. The occurrence of any of these postoperatively should strongly suggest pulmonary embolism.

The electrocardiographic signs usually described for pulmonary embolism are those of *acute cor pulmonale*, an abrupt increase in pressure in the pulmonary arterial circulation. It is well known that even quite small emboli can cause major increases in this pressure, presumably by collateral spasm throughout the arterial branches in both lungs. The resultant "classical pattern" in the ECG—the shift in axis toward the vertical, clockwise rotation, the often wide and slurred S waves in lead I together with Q waves in lead III, the S-T segment depression and T wave inversion in the right precordial leads—doubtless arise mainly from the elevated pressure in the right ventricle. There seems little basis for invoking a reflex coronary insufficiency to explain any of the manifestations of pulmonary embolism, clinical or electrocardiographic. Sinus tachycardia is of course a common accompaniment and atrial arrhythmias, chiefly transient atrial fibrillation, are not infrequent. Another non-specific change is widening of the QRS to 0.10 or so and occasionally conduction is impaired to the point of complete right bundle branch block.

Actually the incidence of this characteristic ECG pattern, like that of the classical triangular density described in roentgenograms of pulmonary infarction, is quite rare. In some cases the abnormalities may be so transient as to be missed, in others they may be masked by pre-existing cardiac disease, and in a few the electrocardiogram may be virtually normal in the

presence of demonstrated pulmonary emboli. (One explanation for the latter situation is that dilatation of the right ventricle with consequent tricuspid insufficiency may supervene and relieve the high pressure in the right ventricle on which the electrocardiographic alterations depend.) However if one looks for individual ECG abnormalities, and particularly for sequential changes in serial tracings, the electrocardiogram can contribute to the diagnosis of pulmonary embolism in about two-thirds of cases. Studies of chest roentgenograms in similar large series of cases have indicated about a 75 per cent incidence of abnormal pulmonary findings, many of them comparably non-specific.

If it is true that "pulmonary embolism has become the most common disease of the lungs encountered in general hospitals" and that if searched for it is found in about 10 per cent of routine autopsies as has been contended,¹ many signs of the disease must be more subtle than is generally supposed.

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POSTOPERATIVE COMPLICATIONS— I. ADYNAMIC ILEUS

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Assistant Professor of Surgery

Adynamic ileus occurs frequently in the immediate postoperative period. Usually, it produces minimal symptoms and discomfort to the patient. Moderate to severe degrees of ileus cause the patient much discomfort and can result in serious sequelae if not promptly recognized and treated. The following case is one in which ileus was progressive. It was recognized and managed effectively.

E. M. was a 54 year old colored female admitted to the Medical College Hospital on May 16, 1960. She had been treated with X-ray irradiation for carcinoma of the cervix in April, 1954. In March, 1960, a large abdominal mass was palpated and was associated with symptoms of bowel obstruction. Laparotomy was carried out and a large cyst was drained. Because of the persistence of the abdominal mass, she was readmitted for operative removal. On May 18, 1960, a large multicystic mass arising from the right ovary was removed. Pathological examination revealed this to be a pseudomucinous cystadenoma of the left ovary.

Two days following operation the patient complained of abdominal pain. There was mild temperature elevation and increased pulse rate. The abdomen was moderately tender. Rebound tenderness was present but not localized. Peristalsis was hypoactive. The following day her condition had not changed. On the fourth postoperative day her abdomen was more distended and she began to vomit. A gastric suction tube was inserted. An upright abdominal film was ob-

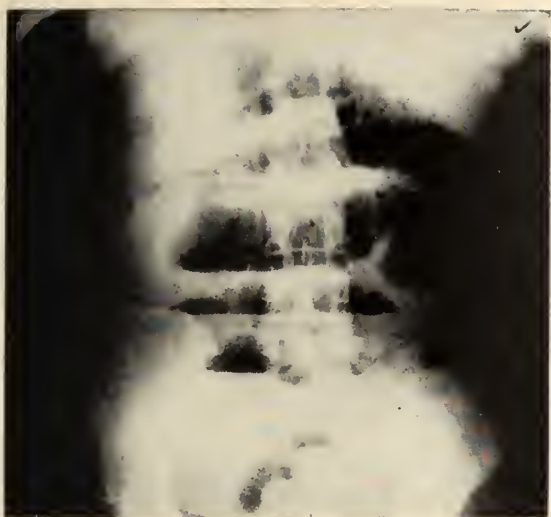


Figure 1

Abdominal roentgenogram on fourth postoperative day demonstrating small bowel distended with gas and fluid.



Figure 2

Abdominal roentgenogram on sixth postoperative day showing subsidence of small bowel distention and normal gas shadows in portions of the large bowel.

tained which demonstrated small bowel distention and fluid levels (Figure 1.). A diagnosis of adynamic ileus was made although small bowel mechanical obstruction could not be ruled out. Serum electrolyte determinations were within normal limits. A conservative program was elected.

The clinical picture improved rapidly and in two days peristalsis was effective. A repeat abdominal roentgenogram showed marked diminution in gas and fluid in the small bowel with a moderate amount of gas in the colon (Figure 2). The patient progressed to a regular diet before discharge on May 29, 1960.

Discussion

This case is typical of postoperative ileus progressing to the degree that makes its differentiation from mechanical small bowel obstruction difficult. Had this patient been reoperated upon, fibrinous adhesions would have been found and possibly considered as the cause of obstruction. The patient would have sustained another metabolic insult and the period for establishment of effective peristalsis would have begun all over again.

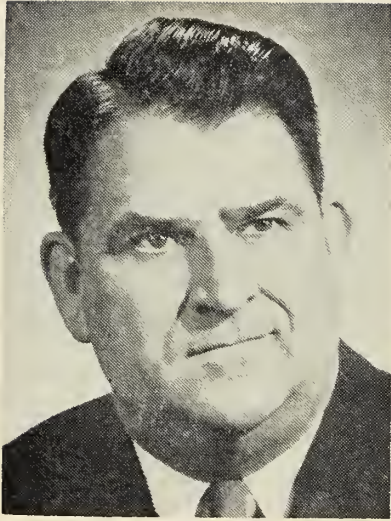
Postoperatively, varying degrees of adynamic ileus occur and are due to reflex sympathetic inhibition of peristalsis, especially when intraabdominal or retroperitoneal procedures are done. Return of effective peristalsis is heralded by audible bowel sounds and passage of flatus. Bowel sounds are sometimes heard, however, before peristalsis is effective. Usually when ileus is anticipated, a gastric suction tube is inserted and removed one to several days postoperatively. If ileus continues beyond this time, it is most likely because of prolonged sympathetic inhibition but other causes such as uremia, hypokalemia, hyponatremia, infection, and pancreatitis should be investigated. A low serum potassium or sodium concentration, or an

elevated BUN or serum amylase would aid in clarifying the etiology.

The triad of distention, dehydration, and electrolyte imbalance accompanying ileus can quickly cause death if not corrected. The gaseous distention is largely due to swallowed air accumulating in the paralyzed small intestine. This distention increases intra-abdominal pressure, decreases diaphragmatic excursion, and increases the hazards of venous thrombosis and embolism. Dehydration is brought on by the accumulation of large volumes of saliva, gastric juice, bile, pancreatic juice, and succus entericus in the lumen of the small intestine. Electrolyte deficits result when these fluids are not reabsorbed.

Treatment should be mainly non-operative. With intubation, correction of fluid and electrolyte imbalances, especially hypokalemia, the ileus will usually completely subside. A focal area of infection can usually be detected as abdominal distention subsides and proper drainage can be established. Hasty reoperation prior to the tenth to fourteenth postoperative day should be avoided as the patient's condition will invariably be worsened. If after adequate decompression, the patient is still obstructed or if there was a normal postoperative course for seven or more days prior to the beginning of distention, an organic lesion must be strongly suspected and laparotomy carried out after suitable preparation. An explosive onset with clear localizing signs of bleeding or leakage after an abdominal operation is reason for early reoperation.

The important principle is that reoperation added to postoperative ileus will often result in a fatal outcome, a shocklike state, or the development of intraperitoneal infection. With conservative measures, the clinical picture will subside or other cause will be revealed.



President's Pages

CIVIL DEFENSE

Civil Defense in South Carolina is fast becoming a tangible thing, whose need is becoming recognized by the general population, and whose organization and influence is gradually entering in each County of the State. This general awakening is something long overdue. A great deal of interest has recently been manifest in Civil Defense, and probably more emphasis has been given to it since the failure of the Summit Conference earlier this year than at any time during the last ten years. Add to this the organization of so called "rescue squads" in many communities and the realization comes

that Civil Defense is not some strange far-fetched program, but a tangible community asset which functions not only against atomic attack about which some people have a fatalistic attitude, but also to help in our many daily emergencies—hurricanes, floods, auto and train wrecks, water accidents, etc.

Prior to the inauguration of Governor Hollings and through his efforts, along with the cooperation of then Governor Timmerman and the State Legislature, the office of Civil Defense in South Carolina was expanded from a one man low budget department into a greatly enlarged personnel, with an increased budget which, however, is still limited. Mr. Charles Culbertson is head of the State Civil Defense in South Carolina, ably assisted by Col. Collier. These two men, whose offices are in Columbia, have supervised the organization of Civil Defense in South Carolina until now each County has an interested and able County Chairman, who has extended his organization into each of the principal cities within the various counties.

Medical responsibility in Civil Defense is tied into the overall picture. It follows a separate chain of command which is under a Chief Medical Director, also responsible to Director Culbertson. At the present time, however, it is my opinion that the Medical Civil Defense is not nearly so well organized as are the other branches of Civil Defense. It is necessary for us to offer more interest and cooperation in order to remedy this situation. It is paradoxical that we are lagging along in our medical organization, when a large part of the credit for reorganization of all civil defense on a statewide basis due to one of our own members, Dr. Charles Wyatt, of Greenville.

Back in 1955 when our State Convention met in Charleston, we were presented a request from the State Board of Health that Council take over the medical organization of civil defense. The officer in charge of medical organization who had been assigned by the State Board of Health, had been able to get absolutely no cooperation from the then director of Civil Defense. He had butted his head against a stone wall the entire time and, realizing his inability to get anywhere with the situation, asked Council to take over—which it did.

Council appointed Dr. Charles Wyatt as Chairman of its Civil Defense Committee, and Dr. Wyatt went immediately to work. He organized the State by having the Councilors in each district appoint a physician in charge of Medical Civil Defense for his district and they in turn appointed physicians in charge of each county.

In the beginning, Dr. Wyatt butted up against the same stone wall. However, he bounced back and kept butting, and eventually started to make some progress.

Dr. Wyatt attended all the conferences that A. M. A. had to offer and all of those offered by the National Civil Defense. He secured a firm grasp of the entire situation and in my opinion knows more about Civil Defense than any other doctor in South Carolina at the present time.

It is gratifying to note that Dr. Wyatt's suggestions, along with those of other interested persons, were closely considered by the State Legislature when the State Civil Defense Department was reorganized to its present efficient status.

Unfortunately we have not been able to secure a Medical Director with sufficient time to devote to the problem and many, if not all, of the physicians in charge of districts, and also those in charge of the various counties have lost interest. This is primarily because of their inability to secure adequate information as to what was expected of them, and adequate educational and organizational help. I would say at the present time, in most counties, that active civil defense throughout South Carolina is nonexistent from a medical standpoint. However, planning continues and some light appears in the future.

Along with the State reorganization, with central quarters in Columbia, came the request that the Medical Association appoint an active administrator from the Medical Association living in Columbia, who could coordinate the medical efforts with other areas of civil defense. Dr. Manly Hutchinson of Columbia was appointed to fill this position. Last year the medical defense was reorganized again so that a chain of command could go down through the various districts, with the President of the Association being the Chief Medical Officer in the State, and the President-Elect of the Association being Deputy Chief Medical Officer of the State. Dr. William Weston, Jr., last year during his office as President of the Association, served as Chief Medical Officer. This year, since I live in Mullins and away from the center of the state, I requested that the Medical Association ask Dr. Weston to continue to serve as Chief Medical Officer, and I would continue to serve as his Deputy. The Association agreed, stipulating however that as soon as feasible Council appoint a medical officer, preferably residing in Columbia, who could take over the job on a permanent basis rather than have it change each year with the President of the Association. Dr. Weston kindly consented to do this, and at present is still acting as our Chief Medical Officer.

At a recent meeting in Columbia with Mr. Culbertson, Dr. Wyatt, Dr. Weston, Dr. Gressette, Mr. M. L. Meadors and myself, we surveyed the possibility of securing a full time Civil Defense Medical Officer on a full time salary, whose duties it would be to meet with Hospitals, Medical Associations, and doctors throughout the state and really get our medical organization going. We intend to take this matter up with the Budget Control Board when it meets in November, and would ask that all of you speak to your Senators and Representatives concerning the feasibility of increased appropriation in order to pay such a person's salary.

As a matter of further interest, the State of South Carolina has been zoned into areas of attack and into areas of evacuation. To the various counties listed as evacuation counties have been made available 200 bed field hospitals on a loan basis from the Government, to be kept stored in a convenient location and available to be set up and operated in time of emergency. Each of the 12 hospitals already allotted have their medical staff set up as part of the requirements, before the hospital was granted. Ten more hospitals are available and will be allotted in the near future.

Joseph P. Cain, Jr., M. D.

Editorials

SCANDALS IN THE FUNDS

It is unfortunate that periodically there comes to light some dire dereliction in the management of the funds accumulated from the public for charitable purposes. While one bad example does not reflect upon the many substantial and fully approved organizations, when one organization goes sour, there is an increased interest in knowing what is happening in the others which are still unquestioned.

The Sister Kenny fund was set up a number of years ago to promote development of the supposedly original methods developed by its namesake. While these methods did not revolutionize treatment, the interest created by them resulted in the development of a voluntary organization which was to exploit the procedures and to extend itself to helping with crippling diseases, especially poliomyelitis. The Fund has continued to solicit money, and has obviously accumulated a very considerable amount as is indicated by the recent public announcement that the executive director had managed to accumulate for himself over a period of fourteen years some \$604,500.00. It appears further that during the past seven years only 47% of the money raised has been applied to treatment, hospitalization, research and training, the balance having gone into solicitation and propaganda. Even more glaring is the figure which has been given for the distribution of funds from the 1956 campaign. It appears that of the money collected during that year, only 1.5% was applied to medical purposes; the rest went for promotion.

Such unbelievable dissipation of funds obtained for a good purpose certainly will react most unfavorably on the fund concerned, and probably to some extent on other funds. It seems that it would behoove us to inquire carefully into the activities of those organizations which we have considered as sound and desirable; nearly all of them are quite willing and anxious to have public inspection of the way in which their money is handled and dis-

bursed. Only one of the groups which operates in this state is subject to the criticism that it has made no announcement of its specific objectives and has not accounted for the money which has been contributed by our citizens.

APATHY AT A NEW LOW

A short time ago there was held in New York's famous Madison Square Garden a large and enthusiastic gathering of some 15,000 elderly persons, brought there with the thought that their vocal evidence might emphasize their idea that the aged need medical care and the Forand Bill is the way to get it.

This gathering was assembled through the efforts of the Council of Golden Ring Clubs composed mainly of retired union members. The assembly expressed vociferous approbation of Forand, George Meany, Francis Perkins, Senator Lehman, and Mayor Wagner, all of that undesirable element which supports and pushes the passage of legislation for compulsory medical insurance. From the standpoint of its sponsors and its participants, the meeting was highly successful.

With serious possibilities of the introduction and passage of measures for compulsory insurance which would react most undesirably on the medical profession, one would have expected some sort of determined reply by the profession of New York. A few days after the "old age" gathering, a meeting was called by New York's Medical Society of the County of New York, which includes 7,000 members, to discuss and determine a policy on medical aid to the aged. For official action a quorum of 100 was required, but no action was taken, as only 78 out of the 7,000 potential participants in the meeting appeared.

There must be two conclusions to this story. One would be that the Medical Society of the County of New York was so much in favor of the proposed measures that it felt no

need to make any official statement. The other might be that physicians in New York are even more apathetic about meeting the challenges of such demonstrations than are physicians elsewhere. It is probably fair to say that even benighted South Carolina would have done better than enlightened New York.

A VERY SPECIAL GIFT

Each fall millions of Americans respond generously to the call of their United Fund, Community Chest, Good Neighbor Fund, or similarly named United way campaign. Last year they gave a combined total of \$455 million to support 28,000 voluntary health and welfare agencies serving 81.3 million men, women and children.

Those are impressive figures. They verify our belief that Americans are truly warm-hearted. We feel particularly strong about this right now because we've been listening to cynics tell us how remote we are from each other, how little we care about our fellow man.

Researchers have dug up coldblooded facts that charge us with giving from habit, from social pressure, from desire for community status, guilt feelings, or for "insurance" against the time we ourselves need help. That may be true of some of us, but we're sure there's more to it than that.

The habit of kindness does not die easily. We've had it instilled in us too long. It's deeply rooted in our heritage.

Most people give because the warmth and satisfaction of giving is unmatched by any other feeling. When we give to United Community Campaigns, in particular, we know that our one gift means unwanted babies will find homes full of affection and laughter, boys and girls will be taught self-reliance, the sick in mind and body may be healed and the aged given renewed faith in the future. We give the United way because we know our gift helps people like ourselves to remain proud and strong and in every sense of the word, alive.

REPORT ON THE 1960 WHITE HOUSE CONFERENCE ON CHILDREN AND YOUTH

by

Walter Moore Hart, M. D.

The Golden Anniversary 1960 White House conference on Children and Youth was a partnership of people and of organizations. Called by President Eisenhower, its purpose was "to promote opportunities for children and youth to realize their potential for a creative life in freedom and dignity".¹ Its focus was on (a) The study and understanding of the values and ideals of our society; (b) The effects on development of children and youth of the rapid changes in this country and the world; (c) How family, religion, the arts, government, community organizations and services such as Health, Education, and Welfare, peer groups, and the behaviour of adults in their interactions with children and youth deter or enable individual fulfillment and constructive service to humanity.²

The first White House Conference was called in 1909 by President Theodore Roosevelt. This was a conference on the care of dependent children and gave impetus to the establishment of the United States Children's Bureau in 1912, the enactment of Child Labor Laws, and organization of the Child Welfare League of America. Subsequent conferences were called by Woodrow Wilson in 1919, Herbert Hoover in 1930, Franklin D. Roosevelt in 1940, and Harry S. Truman in 1950.

On November 7, 1958, President Eisenhower appointed a 92-member National Committee to be responsible for organization of the 1960 Conference. This committee was composed of leaders in education, health, social work, recreation, religion, and many other fields related to children and youth. This group determined that 7,000 delegates could be cared for and handled in the Conference. Delegates were apportioned to the states, national organizations such as the National Education Association, American Medical Association, churches, and labor groups, and 500 were apportioned to foreign countries. It was decided that 1,000 or 14% of the total should be young people 15 to 21 years of age. South Carolina was allocated 44 places, and we had another 15 representing national organizations.

At the opening session President Eisenhower addressed the entire group during which he termed young people "the most precious resource of our nation—a whole generation of Americans who will someday make this country's policies and dispose of its great power. I have an unshakable faith in the overwhelming majority of fine, earnest, high-spirited youngsters who comprise this rising generation of Americans. They possess a more intense intellectual curiosity than we of my age exercised when we were their age."

Following the opening session, the Conference was

broken into groups of varying size. For the next three mornings we would meet first as five theme assemblies and later in the morning divide into eighteen forum groups. After dinner we met in 210 work groups of approximately thirty persons each where matters of concern to children and youth were discussed in detail by the participants. The field of discussion was determined by a very elaborate program, there being in many cases more than one group discussing the same general sphere of life. Resolutions were prepared in the work groups and later edited by the work group leaders and the forum leaders. At the forum meetings on the fourth afternoon, the resolutions were voted upon. It was thought that the resolutions committee would be able to edit these and have them printed for distribution at the final meeting on the fifth morning, but this proved to be an impossible task when they were faced with more than 1600 resolutions. The committee on composite forum recommendations worked for several weeks consolidating these and arranging them into a booklet containing 670 resolutions. Since the committee was allowed to editorialize and consolidate but not alter the resolutions, they have reported out a booklet which is of little value because of its vastness and lack of conciseness.

What was accomplished in Washington between March 26 and April 1? The fact that 7,602 registered delegates, including 500 international visitors representing 73 foreign countries, met together in Washington for six days is accomplishment enough. Surprisingly, the Conference was financed by private individuals and organizations and not by tax monies. We learned a lot, we exchanged ideas, and each person seemed to gain new insight into problems in other areas of the country. We entered with a microscopie view and departed with a telescopic view.

When the Conference terminated, we felt quite confused. The Washington Post in an editorial on April 1 said in part: "the very degree of the conferees frustration may be the real gauge of the success of the Conference. The delegates ought to return home more disturbed than when they arrived about the inadequacies in education, in home life, in youth's relation to the community—more conscious than they were of the nation's slow progress in solving these problems. We hope, indeed, that they will go home concerned enough to work harder on these issues in the next ten years than they have in the last ten."

In preparing for the White House Conference, states and organizations conducted studies and surveys to determine the status of affairs in their particular area. The South Carolina Committee on Children and Youth, organized in 1947, was designated by Governor Thurmond to prepare the survey for the 1950 White House Conference. This resulted in the booklet "Planning for South Carolina's Children and Youth". This committee, made up of representatives of private and public agencies and financed by \$1.00 dues for each member, has continued to function in projects for children and youth. In July 1958, this

same group began plans for another but more extensive survey for the 1960 White House Conference. Some 5,000 persons assisted with the survey now summarized and published as "Unlimited Opportunities Beckon South Carolina Youth". This booklet is available for the asking from the South Carolina Committee on Children and Youth, Post Office Box 1108, Columbia, South Carolina. In this booklet is found a summarization of the facts about the situation as pertains to children and youth in South Carolina in various fields of endeavor. Study was made specifically in the fields of education, health, law enforcement, courts and legal aids, public library service, recreation, religious and moral instruction, social services for children and youth, and youth employment.

Priorities for action for 1960-1970 were drawn from the recommendations made at the end of each of the composite county reports. United and coordinated effort by all South Carolinians will help to assure progress toward accomplishing these goals over the next ten years.

Priorities For Action For 1960-1970.

1. Increase per pupil expenditure for education as a first step toward improving the quality of education.
2. Place the enrollment and average daily attendance requirements for state aid on the same basis for both elementary and secondary schools, thus reducing the class size in the elementary school.
3. Examine the tax structure with a view to bringing about a more equitable assessment of property for tax purposes.
4. Expand child health clinics and conferences to include more medical supervision of children and more counseling with parents.
5. Increase the number of mental health clinics and establish a Child Development Research-Diagnostic-Treatment Center.
6. Provide more adequate funds to secure trained personnel (doctors, nurses, and allied professions) in public health, mental health, obstetrics, and pediatrics.
7. Develop more organized and coordinated efforts of all community resources—private and public—for optimal health and welfare of mothers, children, and youth.
8. Make available juvenile courts for the hearing of cases of all juvenile offenders and staff courts with qualified personnel.
9. Provide for a social study of each case by a qualified person prior to the hearing of the case before the court.
10. Develop a larger system of public library service through the establishment of regional libraries to make possible the provision of more books, children's specialists, and additional services to children and youth.
11. Establish a State Recreation Commission staffed with personnel to advise and to assist counties and municipalities, churches, private agencies, industries, and other groups on their recreation needs and problems.

12. Enact laws permitting the use of county funds for the establishment of county recreation departments.
13. Provide more leadership training courses, family life education, and premarital counseling through the church.
14. Develop more awareness on the part of the church as to its opportunities for helping young people attain spiritual strength and develop a moral code on which to base their actions.
15. Expand homemaker and day care service to help in holding families together.
16. Strengthen legislation affecting children in the following areas:
 - (a) Adoption laws
 - (b) Child labor laws
 - (c) Marriage laws
17. Abolish laws which permit deeding and indenture of children.
18. Enact state labor legislation to coincide with Federal Child Labor laws.
19. Require employment or age certificates for young workers under 18.
20. Coordinate the efforts of local and state agencies offering vocational guidance services.³

The South Carolina Committee on Children and Youth at a meeting on June 15, 1960, agreed to work on, for immediate action, the four priorities listed above as numbers 16, 17, 18, and 19. These priorities, it is believed, will require little or no allocation of funds from either local or state governments. At a meeting of the South Carolina Delegation to the White House Conference on Children and Youth in Columbia on July 26, 1960, it was agreed that we too would endeavor to see that these goals are attained in the near future. Each member of the South Carolina Medical Association should acquaint himself with these priorities and do what he can to see that they are accomplished.

REFERENCES

- (1) Theme of 1960 White House Conference on Children and Youth.
- (2) Mrs. Rollin Brown, National Chairman, Golden Anniversary White House Conference on Children and Youth, in Foreword to "Focus on Children and Youth", page v.
- (3) "Unlimited Opportunities Beckon South Carolina Youth!", page 5.



BLUE CROSS . . . BLUE SHIELD



Blue Cross - Blue Shield led all other organizations in the enrollment of federal workers who became eligible for coverage under the Federal Employee Health Benefits legislation enacted last year. A spokesman for the Blue Cross and Blue Shield national offices said that more than 55 per cent of the estimated 1,695,000 federal workers who selected health benefits coverage from among the 38 programs available chose to enroll in Blue Cross - Blue Shield.

Nearly complete tabulations of the distribution of enrollment between the various programs which were released by the Civil Service Commission in late July indicated that enrollment in Blue Cross - Blue Shield was more than twice as large as enrollment in the government-wide indemnity benefits program provided through the Aetna Life Insurance Company which enrolled about 450,000 government workers compared to the Blue Cross - Blue Shield enrollment of 935,000. All other programs, including those

offered by government employee and group health organizations, accounted for but 19 per cent of the total enrollment, or approximately 325,000 enrollees.

In discussing the preliminary enrollment totals announced by the Civil Service Commission, representatives of the Blue Cross Association and the National Association of Blue Shield Plans said that the selection of Blue Cross - Blue Shield by nearly a million federal employees represented "an overwhelming vote of confidence in these community oriented organizations" and made the programs offered by the "Blue Plans" the "coverage of choice" among employees of the Federal Government.

These spokesmen also emphasized that the preference for Blue Cross and Blue Shield reflected in the choice of federal workers followed the pattern of leadership and popularity these Plans have continued to display in the enrollment of large segments of the public at large.



FOUNDERS' DAY — 1960

Founders' Day at the Medical College of South Carolina has traditionally become a sort of combination homecoming and post-graduate course for our Alumni and practicing physicians of the state. As such, it serves a dual purpose, social and professional. Plans this year are for considerable expansion of Founders' Day activities with the hope that many physicians who have not visited their alma mater in recent years will avail themselves of this invitation to be the guests of the College November 17th and 18th.

A streamlined and fast moving scientific program of wide general interest has been arranged, to be presented by five distinguished out-of-state speakers supported by a dozen members of the Medical College Faculty. Subjects range from anemia to acceleration of

labor to evaluation and medical treatment of hypertension to migraine and post-operative complications. There will be a clinical-pathological conference with the guests themselves as the participants, and one afternoon will be devoted to presentation of interesting cases in special clinics throughout the hospitals where the patients can be examined individually and discussed freely. Emphasis throughout will be on recent developments in the medical fields, particularly those applicable to every day practice. On Thursday is the Alumni Luncheon and that evening the annual banquet for members and their wives. The program closes Friday evening with a symposium on a subject of increasing importance in medicine—automobile accidents.

So mark your calendar now and plan to be in Charleston for the 1960 Founders' Day.

PROGRAM FOR FOUNDERS' DAY

THURSDAY, NOVEMBER 17

MORNING SESSION

Presiding, Dr. William O. Whetsell, Pres., Alumni Assoc. of Medical College of South Carolina

8:30 A. M.—Registration — Greetings—Dr. John T. Cuttino

9:15 A. M.—Sickle-Cell Disease—Dr. Paul V. Woolley

9:45 A. M.—Office Procedures in Ophthalmology for the Family Physician—Dr. W. W. Vallotton

10:05 A. M.—Evaluation of the Hypertensive Patient—Dr. John A. Spittel, Jr.

10:35 A. M.—COFFEE BREAK

10:55 A. M.—Diagnosis of the Anemias—Dr. Richard W. Vilter

11:25 A. M.—Dysmenorrhea—Dr. Martin L. Stone

11:55 A. M.—The Office Diagnosis of Cancer—Dr. John C. Hawk

12:15 P. M.—Question period.

12:45 P. M.—ALUMNI LUNCHEON

AFTERNOON SESSION

2:00-5:00 P. M.—Clinics. Conducted tour of Clinics with presentation and informal discussion of interesting cases.

ANNUAL BANQUET, Alumni Association and Guests

7:30 P. M.—Francis Marion Hotel

Refreshments

Dinner. Presiding, Dr. John T. Cuttino, Acting President, Medical College of South Carolina

"Vignette of a Founder—Samuel Henry Dickson", Dr. J. I. Waring

"Medicine and Mankind"—Dr. Frederick A. Collier

FRIDAY, NOVEMBER 18

MORNING SESSION

Presiding, Dr. Martin M. Teague, President, S. C. Academy of General Practice

9:00 A. M.—Management of Insect Sting Hypersensitivity—Dr. Kelly T. McKee

9:30 A. M.—Values and Limitations of Routine Cranial Transillumination—Dr. Paul V. Woolley

10:00 A. M.—Thrombosis and Embolism—Recognition and Management—Dr. Frederick A. Collier

10:30 A. M.—COFFEE BREAK

10:50 A. M.—Postoperative Complications—Dr. Randolph Bradham

11:15 A. M.—The Medical Treatment of Essential Hypertension—Dr. John A. Spittel, Jr.

11:45 A. M.—Question Period

12:00 Noon—Clinical Pathological Conference—Dr. H. Rawling Pratt-Thomas

1:00 P. M.—LUNCH

AFTERNOON SESSION

Presiding, Dr. Dale Groom, Ass't. Professor of Medicine, Medical College of South Carolina

2:00 P. M.—Migraine—Diagnostic and Therapeutic Considerations—Dr. Neil Marshall

2:30 P. M.—Treatment of the Anemias—Dr. Richard W. Vilter

3:00 P. M.—Acceleration and Induction of Labor—Dr. Martin L. Stone

3:30 P. M.—COFFEE BREAK

3:45 P. M.—Office Diagnostic Procedures in Renal Disease—Dr. Cheves M. Smythe

4:05 P. M.—Question Period

4:20 P. M.—Symposium on Automobile Accidents

Dr. Frederick Kredel, Moderator Dr. Kenneth Lynch, Jr.

Dr. John Arthur Siegling Dr. Gordon T. Wannamaker

Dr. O. Rhett Talbert Mr. Coming B. Gibbs, Attorney-at-Law

FACULTY

GUEST SPEAKERS

Richard W. Vilter, M. D.; Professor of Medicine, Univ. of Cincinnati College of Medicine; President, American Society for Clinical Nutrition.

Frederick A. Collier, M. D.; Professor, Emeritus, of Surgery, Univ. of Michigan; Fellow, Royal College of Surgeons (Edinburgh and England); Past President of American College of Surgeons and of American Surgical Society.

John A. Spittel, Jr., M. D.; Consultant in Internal Medicine, Mayo Clinic and Instructor in Medicine, Mayo Foundation.

Martin L. Stone, M. D.; Professor of Obstetrics and Gynecology; New York Medical College.

Paul V. Woolley, M. D.; Professor of Pediatrics; Wayne Univ. Medical School.

SPEAKERS FROM FACULTY OF MEDICAL COLLEGE OF S. C.

Randolph R. Bradham, M. C., Asst. Prof. of Surgery

John C. Hawk, M. C., Associate Professor of Surgery

Frederick E. Kredel, M. D., Prof. of Surgery

Kenneth M. Lynch, Jr., Professor of Urology

Neil Marshall, M. D., Associate in Neurology

Kelly T. McKee, M. D., Associate Prof. of Medicine

H. Rawling Pratt-Thomas, M. D., Prof. of Pathology and Dean, School of Medicine

John A. Siegling, M. D., Clinical Professor of Orthopedic Surgery

Cheves M. C. Smythe, M. D., Asst. Prof. of Medicine

O. Rhett Talbert, M. D., Asst. Prof. of Neurology

W. W. Vallotton, M. D., Assoc. Prof. of Ophthalmology

Gordon T. Wannamaker, M. D., Asst. Prof. of Medicine

NEWS

NEW PHYSICIANS ARE GRANTED LICENSES TO PRACTICE IN STATE

MEDICAL EXAMINERS BOARD LISTS SUCCESSFUL GROUP

The State Board of Medical Examiners reports that a total of 55 physicians have passed board examinations and have been licensed to practice in South Carolina.

They are: Drs. William E. Alverson, Greer; Grover L. Anderson, Camden; David G. Akins, Jr., Marion; Carl C. Bailey, Jr., Clemson; Carol R. Bell, Lamar; Thomas E. Breeden, Bennettsville; Barry A. Bukatman, Charleston; Samuel N. S. Bultman, Sumter; Maria F. C. Buse, Charleston; William L. Coleman, Pamplico; Hal H. Crosswell, Jr., Columbia; Michael R. Culler, Orangeburg; Thomas F. Drake, Jr., Anderson; Jack N. Dunn, Blackville; William B. Evins, Jr., Travelers Rest; Simon W. Eyer, Charleston; Walter L. Gaillard, Williamston; William D. Gilmore, Jr., Walhalla; James S. Godwin, Charleston; Winfield Hardy, Salem.

Also, Drs. Edward L. Hay, Wadmalaw Island; William R. Haynie, Belton; Charles W. Hinnant, Bamberg; William P. Hood, Jr., Hickory Grove; Leslie W. Howard, Jr., Columbia; Leon E. Hunt, Winnsboro; Arthur C. Hutson, Jr., Seabrook; Charles W. Johnson, Jr., Clinton; Frankie F. Johnson, St. George; Cecil F. Lanford, Woodruff; Julius R. Lawson, Sumter; Boyce M. Sawton, Jr., Estill; Watt McCain, Jr., Orangeburg; Robert L. McCurdy, Florence; James C. Mitchell, III, Summerville; Charles A. Mood, Sumter; Edward C. N. O'Bryan, Jr., Florence; Douglas C. Owens, Easley; William F. Parker, Jr., Sumter; William E. Prier, Greenville.

Also, Drs. James R. Pruitt, Rock Hill; James F. Richardson, Simpsonville; Dexter B. Rogers, Easley; William H. Rudnick, Sullivan's Island; Laurie N. Smith, Spartanburg; Boyd W. Springs, Cherry Grove Beach; Charles E. Stark, Jr., Edgefield; Louis M. Stephens, Clinton; Robert R. Taylor, Jr., Columbia; James M. Tenney, Charleston; William G. Whitlock, Lake City; James T. Wiggins, Union; Samuel N. Workman, Laurens; Louis D. Wright, Jr., Columbia, and Frank C. Young, Jr., Clinton.

POLIO SHOTS NEGLECTED IN STATE

A national Foundation spokesman said on August 3 "A conservative estimate" reveals almost 60 per cent of South Carolina's population has not even had one inoculation against infantile paralysis.

The spokesman also said State chapters of the foundation are considering an emergency March of Dimes appeal this fall because of the current outbreak in the state and to make people aware of the need to be vaccinated.

The State Health Department announced that 14 new cases of polio were reported in the state the week before. Nine were in Spartanburg and Cherokee counties. There also has been an outbreak in nearby Cleveland County, N. C.

So far this year there have been 49 cases, 30 from the Spartanburg - Cherokee County area. Last year at this time 22 cases had been reported.

Dr. G. E. McDaniel, director of the Health Department's division of disease control, said 34 of this year's 49 cases were paralytic. And 30 of the 34 had had no vaccine at all.

Dr. Melvin B. Nickles, Jr. has become affiliated with Drs. Dibble and Berry in the general practice of medicine in their offices at Florence, S. C.

Dr. Nickles was graduated from Clemson College in 1955 and from South Carolina Medical College in 1959. He recently completed an internship at Greenville General Hospital in Greenville.

He is the son of Dr. and Mrs. Melvin H. Nickles, Sr. of Laurens.

Dr. T. R. Wynne has his offices at 3 Medical Ct., Greenville. He received his B.S. and M.D. degrees from the University of North Carolina.

DR. TEMPLES RESUMES PRACTICE

Dr. P. M. Temples of East Peachtree Street has reopened his office for the general practice of medicine following an extended stay at the U. S. Naval Hospital in Charleston. He underwent surgery at the Charleston Hospital and has been reported as recuperating nicely to the extent that he is now able to resume his medical practice at Woodruff.

MYRTLE BEACH ORTHOPEDIC CLINIC

Dr. George R. Dawson, Jr., Orthopedist from Florence, will hold an Orthopedic Clinic at the Ocean View Memorial Hospital, Myrtle Beach, the 2nd and 4th Thursday of each month.

Dr. Dawson is a graduate of the Citadel, and The Medical College of South Carolina. He interned at Roper Hospital, Charleston, and was a resident in surgery there. In his last year of residency, he was a teaching fellow at the Medical College of South Carolina. His residency in Orthopedics was done at John Hopkins University, Baltimore, and the New York Orthopedic Dispensary (Columbia Presbyterian Medical Center).

He is consulting Orthopedist at McLeod Infirmary, Florence and at many other hospitals in this area. He is also a consultant at the South Carolina Crippled Children's Home in Florence, and the Orthopedist in charge of the Crippled Children's work in the Pee Dee Section.

SUMTER DOCTOR GETS FELLOWSHIP

Dr. Jack W. Chandler, Jr. of Sumter has been awarded a Wyeth Laboratories pediatric residency

fellowship, and will take his training at the Medical College of South Carolina.

Dr. Chandler, a graduate of the Medical College, completed his internship at Medical Center Hospitals, Charleston, and recently served as chief of out-patient services at Greenville, Miss., Air Force Base Hospital.

The program, sponsored by the Wyeth Fund for postgraduate medical education, provides a grant of \$4,800, enabling a person to spend two years of advanced study in the care and treatment of children.

DR. ELAM BUYS BREEDIN CLINIC

The office of Dr. L. P. Elam, Calhoun Falls physician, will be housed in new and larger quarters. Announcement has been made that the doctor has purchased the Breedin building on the Mt. Carmel Highway.

DR. TALBERT SPEAKS AT COLORADO SEMINAR

Dr. Rhett Talbert of Charleston, lectured on the medico-legal aspects of neurology at the Law-Science Academy of America held in Crested Butte, Colorado.

Medical specialists and trial lawyers from throughout the United States participated in the course.

Dr. Ben N. Miller of Columbia was named president of the General Alumni Association of Duke University at a meeting held recently at the University.

DOCTORS OPEN OFFICES

Two new doctors have opened offices in Hartsville. They are Charles H. Owens and Edward Sutherlin Williams.

Dr. Owens' office will be at 1310 Sixth Street, and Dr. Williams will be located at 1509 Home Avenue.

Dr. Charles H. Owens is a native of Avondale, N. C., and graduated from the schools there and Davidson College. He graduated from UNC School of Medicine in 1954.

Dr. Williams was born in Greenville, N. C. and received his M. D. degree from the UNC School of Medicine in 1954.

Dr. Carl H. Strom has announced the opening of his office at McCormick, S. C. Dr. Strom formerly practiced medicine in Cliffside, N. C.

Dr. Albert W. Bailey, pathologist will be associated with Dr. Hunter May in the practice of pathology in Greenwood, S. C.

Dr. Bailey took his medical training at the University of Georgia School of Medicine in Augusta where, for the past three years, he has served as assistant professor of pathology.

Mrs. Bailey, also a physician was graduated from the University of Georgia School of Medicine. She has been physician for the Georgia Training School for Mental Defectives.

Dr. Virgil Harvey, Jr. has announced he will open his office in Olanta, S. C. for general practice in the offices formerly occupied by the late Dr. E. H. Thomason.

Dr. Harvey has just completed his intern work at the Greenville General Hospital in Greenville, S. C. and prior to that graduated from the Medical College of South Carolina at Charleston.

Dr. Sidney T. Griffin and Dr. Lucius W. Heriot, Jr. have opened offices in Lamar for the general practice of medicine. They will also operate Lamar Hospital.

The two doctors recently completed intern work at the Spartanburg General Hospital in Spartanburg.

Dr. Jake King Holcombe, formerly of Easley, completed his internship at General Hospital in Greenville June 30 and opened offices in Liberty this week for general practice.

A graduate of Easley High School in 1946, Dr. Holcombe received a B. S. degree from the school of pharmacy at the state medical college in 1954, and in 1959 he received an M. D. degree from the South Carolina Medical College at Charleston.

Dr. Samuel R. Shannon has announced the opening of his office in association with Dr. Lawrence V. Jowers at 1634 Taylor Street, Columbia, for the practice of general medicine.

Dr. Shannon received his pre-medical education at the University of South Carolina, 1952-1955. He attended the Medical College of South Carolina and received his M. D. degree in June of 1959.

His internship was completed at the Columbia Hospital. He is a member of the American Academy of General Practice and the Columbia Medical Society.

Dr. Pierre G. Jenkins of Charleston, was recently elected President of the Huguenot Society of South Carolina.

DR. COLE JOINS DR. DUNN

Dr. Roger W. Cole has become associated with Dr. Shepard N. Dunn at 1718 Hampton Street, Columbia, S. C. Their practice will be limited to diseases and surgery of the eye.

WHITTEN VILLAGE GETS BEQUEST OF NEARLY \$50,000

Whitten Village, the state institution for mentally retarded children, has received a bequest of medical equipment valued at between \$40,000 and \$50,000.

Director B. O. Whitten of the village near Clinton said the gift comes from the late Dr. E. T. Kelley of Georgetown.

The institution will get all furnishings and supplies of the Kelley Clinic at Georgetown. Whitten said they will help in equipping a new hospital planned for the village and on which construction will start in September.

Julian P. Price, M. D., Walter Moore Hart, M. D. announce the association of David C. McLean, M. D. Practice limited to Pediatrics at 248 South Irby Street, Florence.

Dr. Jesse L. Bozard, has become associated with Dr. Lawrence Crowl in the general practice of medicine at 1298 Pendleton Street, Greenville.

Dr. Joseph E. Crosland, who has practiced at this address for the past 20 years, will continue to remain in private practice in the same building.

Dr. Bozard, a native of Orangeburg and a graduate of the Medical College of South Carolina, has completed his training at Greenville General Hospital.

He has previously served four years with the U. S. Air Force Medical Corps.

William A. Wilkes, M. D. announces the association of Herbert S. Harper, M. D. in the practice of Pediatrics at 1453 Harper Street, Augusta, Georgia.

MEDICAL COLLEGE GIVEN RESEARCH BUILDING GRANT

South Carolina Medical College officials were notified on August 3 of approval of a \$498,283 grant for a million-dollar medical research building by the U. S. Public Health Service.

Dr. John T. Cuttino, president of the medical college, said the approval meant an immediate go-ahead on plans for the research building which is expected to cost \$996,556.

Dr. Cuttino said architects had begun work on plans for the seven-story building and bids would be asked in three or four months with construction beginning in December or January. The building will house a research program covering almost the entire field of scientific medicine—concentrating on heart diseases and cancer.

Dr. Cuttino said the research program to be conducted in the building amounts to about a million dollars through private or federal sources.

The site for the building was not announced but is expected to be adjacent to the medical college hospital.

Dr. Cuttino said the building will provide 40,158 square feet of floor space for the program. Planning for the technical and scientific needs of the research program have been discussed and detailed for architects, he said.

The building design, although not completed, will be along the same architectural style as the medical college hospital. Brick construction will be used.

Surgeon General Leroy E. Burney announced approval of the grant to the medical college. It was one of the first 66 awarded by the Public Health Service from appropriations for the new fiscal year, which started July 1.

The Health Research Facilities Program, under which it was awarded, provides for the federal gov-

ernment to grant funds on a matching basis to public and private non-profit hospitals, medical, public health and dental schools and other research institutions to build and equip research facilities.

Dr. Cuttino said financing of the medical college's share of the \$996,566 project was completed in May.

The health research facilities program is administered by the Research Grants Division of the National Institutes of Health.

DR. ORVIN ABROAD

Dr. George H. Orvin, a Charleston psychiatrist is spending a year at Mordsley Hospital in London, England, while taking a post graduate study in child psychiatry. Dr. Orvin left for Europe July 1. The hospital is a branch of the University of London. Upon returning to Charleston, Dr. Orvin plans to specialize in psychiatry. Dr. Orvin is a graduate of the Medical College of South Carolina, class of 1946.

Two physicians have announced the opening of offices for the general practice of medicine at the Mary Black Clinic, Spartanburg.

The doctors are William T. Bonner, M. D., who is re-opening his office there, and Sidney G. Alston, M. D. is opening his office at the clinic for the first time.

On August 1, Dr. Jack A. Patrick, native of St. George, S. C. began the practice of medicine in York occupying the offices of the late Dr. E. E. Strong on Main Street.

A graduate of the South Carolina Medical College in 1957, Dr. Patrick interned at the Medical College Hospital, and has just completed two years service in the U. S. Army.

Robert W. Patton, M. D. announces the removal of his offices to 1169 Oakland Avenue, Rock Hill.

DR. MELVIN NICKLES PRACTICING IN MARION

Dr. Melvin B. Nickles, Jr. has begun the practice of medicine with Drs. Dibble and Berry as of July 16th. He will be associated with them in the practice of medicine at their offices at 1115 North Main Street, Marion.

Dr. Nickles is a graduate of Clemson College, class of 1955, and a graduate of the Medical College of South Carolina. He has recently completed his training at the Greenville General Hospital in Greenville.

While a student at the Medical College of South Carolina, Dr. Nickles was president of the Student Body during his senior year, and a member of the Phi Chi Medical Fraternity.

ANNOUNCEMENTS

DUKE POSTGRADUATE CRUISE

The 5th Medical Seminar Cruise to the West Indies sponsored by Duke University School of Medicine will be held November 9-18, 1960. The medical seminar constitutes 20 hours credit of acceptable Category I Postgraduate Requirements A.A.G.P. A certificate for the number of hours of credit will be issued if desired. Instruction will be held on board ship, *M. S. Kungsholm*, and the program should be of interest to the specialist as well as the generalist.

For further medical details, address Director of Postgraduate Education, Duke University School of Medicine, Durham, North Carolina. For registration and cruise information, write Allen Travel Service, Inc., 565 Fifth Avenue, New York 17, N. Y.

The *Kungsholm* leaves from New York November 9th. Rates from \$230.

THE SOUTHEASTERN ALLERGY ASSOCIATION will hold its annual meeting at the Atlanta Biltmore Hotel, Atlanta, Ga. on Oct. 21 and 22, 1960. Dr. Susan Dees, Duke Hospital, Durham, N. C. is in charge of the program and it sounds as though it is going to be something different and very worth while.

MEETING OF SOUTHERN MEDICAL ASSOCIATION

Physicians of the South are extended an invitation to attend the meeting of the Southern Medical Association in Saint Louis to be held October 31 - November 3, 1960. In addition to the 20 excellent Section programs, a Symposium on Cerebrovascular Disease and a Symposium on the Business Side of Medicine will be presented.

For information write:

Convention Reservation Bureau
Southern Medical Association
911 Locust Street, Room 406
Saint Louis 1, Missouri

The Southeastern States 1960 Cancer Seminar will be held at the Cherry Plaza Hotel, Orlando, Florida, November 16-18, 1960.

The Mecklenburg County chapter of the North Carolina Academy of General Practice will hold a Post-Graduate Symposium November 3, 1960 at the Charlotte Hotel in Charlotte, North Carolina.

S. C. CHAPTER AMERICAN ACADEMY GENERAL PRACTICE 12TH ANNUAL MEETING MEMORIAL AUDITORIUM

Spartanburg, S. C.
September 29 - 30, 1960

Dr. Claude Frazier

"Practical Methods of Determining the Cause of Allergy."

"Some Do's and Don't's of Allergic Management."

Dr. Walter Frommeyer

"Fibrinolytic Enzymes and Clinical Hemorrhage."

"Anemia and the Malabsorption Syndromes; Etiology and Management."

Dr. John Siegling

"Fractures in Children are Different."

"Office Orthopedic Problems."

Dr. William Kirtley

"Modern Therapy in Diabetes Mellitus."

"Complications of Diabetes Mellitus."

Dr. Bert Leming

"Bacteriology."

Dr. John Sites

"Gynecics and Toxemia of Pregnancy."

Dr. Edward S. Orgain

"Controversial Problems related to the treatment of Coronary Artery Disease."

"Heart Disease 1960."

SOUTHERN THORACIC SOCIETY THURSDAY, SEPTEMBER 15, 1960 CHARLESTON, S. C.

1. Tuberculosis in Infancy and Childhood—An Experience in Charleston, S. C.
Presented by Jack R. Paul, M. D., Charleston, S. C.
Discussed by David B. Gregg, M. D., Charleston, S. C.
2. Tuberculin Skin Testing.
Presented by Daniel E. Jenkins, M. D., Houston, Texas
Discussed by Victor C. Vaughn, III, M. D., Augusta, Ga.
3. The Treatment of Tuberculosis in Infancy and Childhood.
Presented by Edwin L. Kendig, Jr., M. D., Richmond, Va.
Discussed by J. I. Waring, M. D., Charleston, S. C.
4. BCG and Chemotherapy in the Prevention of Complications of Primary Tuberculosis in Children.
Presented by Sarah F. Davis, M. D., Birmingham, Ala.
Discussed by Edwin L. Kendig, Jr., M. D., Richmond, Va.
5. Resection for Pulmonary Tuberculosis—A Review and Analysis in over Fifty Resections.
Presented by J. L. Wofford, M. D., Watts R. Webb, M. D. and H. K. Stauss, M. D., Jackson, Miss.
Discussed by Edward F. Parker, M. D., Charleston, S. C.

Thursday Noon Luncheon
Clinical Applications of Lung Function Testing.
George W. Wright, M. D., Cleveland, Ohio
Thursday Afternoon, September 15, 1960

1. The Detection of Early Pulmonary Emphysema—Mass Survey Technique
Presented by Ben V. Branscomb, M. D., Birmingham, Ala.
Discussed by George W. Wright, M. D., Cleveland, Ohio and Ross L. McLean, M. D., Atlanta, Ga.
2. Alveolar Ducts in Emphysema—Studies by X-Ray Microscopy and other Methods.
Presented by Charles Odeer, M. D., New Orleans, La.
Discussed by Herbert C. Sweet, M. D., St. Louis, Mo. and George W. Wright, M. D., Cleveland, Ohio.
3. Pulmonary Disease Caused by Atypical Mycobacteria. Dallas Experience.
Presented by Charles A. LeMaistre, M. D. and Hal J. Dewlett, M. D., Dallas, Texas.
Discussed by John H. Seabury, M. D., New Orleans, La.
4. Pulmonary Disease Caused by Atypical Mycobacteria. Batey Experience.
Presented by Raymond F. Corpe, M. D., Rome, Ga.
Discussed by Albert G. Lewis, Jr., M. D., Tampa, Fla.

Friday Morning, September 16, 1960

1. Methyl Prednisolone in the Treatment of Pulmonary Tuberculosis.
Presented by J. Richard Johnson, M. D., Madison, Wis.
Discussed by Ross L. McLean, M. D., Atlanta, Ga.
2. Co-Existing Histoplasmosis and Tuberculosis.
Presented by A. H. Smith, M. D., State Sanatorium, Ark.
Discussed by Harry E. Walkup, M. D., Oteen, N. C.
3. The Surgical Treatment of Pleural Complications.
Harry E. Walkup, M. D., Oteen, N. C.
Discussed by Edward F. Parker, M. D., Charleston, S. C.

FLORIDA PEDIATRIC MEETING

The Fall meeting of the Florida Pediatric Society will be held at Ocho Rios, Jamaica from November 16-20. Dr. Ralph Platou and Dr. Helen Reardon will be the speakers. Arrangements have been made with British West Indian Airways and Pan American World Airways to furnish seats on regular flights from Miami and return. Rates begin at \$147.00 for double occupancy accommodations and include round trip fare, room, 4 breakfasts and 4 dinners.

For further information write:

M. F. Maynard, President
Tropical Travel Bureau, Inc.
3011 East Las Olas Blvd.
Ft. Lauderdale, Fla.

SOUTH CAROLINA CHAPTER OF THE AMERICAN COLLEGE OF SURGEONS

Greenville, South Carolina

November 4-5, 1960

Scientific Sessions

Nurses' Home, Greenville General Hospital

Friday, November 4th, 2:00 to 5:00 p. m.

1. Studies on Dependency of Thyroid Cancer, Dr. Colen G. Thomas, Jr.
2. The Significance of the Pathology of the Brain and Spinal Cord in Clinical Practice, Dr. A. Price Heusner.
3. Surgical Infections, Dr. Curtis P. Artz
4. Muscular Relaxation and Muscular Relaxants, Dr. David A. Davis
5. Cardiac Arrest, Dr. William Bomar
6. Acute Gangrenous Cholecystitis Following Unrelated Surgery, Dr. Kenneth M. Lynch, Jr.

Saturday, November 5, 9:00 to 11:00 a. m.

1. Tumor Cell Contamination of Operative Wounds, Dr. Colen G. Thomas, Jr.
2. Common Complications in Surgery, Dr. Curtis P. Artz
3. The Significance of the Anatomy of the Head and Spine in Clinical Surgery, Dr. A. Price Heusner.



"That's it Mr. Shmedly, Relax, now I'd like to read your bill."

PHYSICIAN NEEDED FOR PUBLIC HEALTH SERVICE

Dr. R. W. Ball, Chief of the Venereal Disease Control Section of the State Board of Health, writes that there is an opportunity for a young physician to enter Public Health Service, particularly to replace Dr. Richard O. Ballew, who has been Venereal Disease Clinical Consultant assigned by the Public Health Service to South Carolina for the past two years. If a physician can be obtained to replace Dr. Ballew, it is understood that he would definitely be assigned to South Carolina.

The Public Health Service also offers many other positions for the young physician. He can enter the Service as an intern after graduation from Medical School, or as a resident after one year's internship. Many of the United States Public Health Service hospitals are approved as teaching hospitals and offer residencies and some of them offer internships. The commissioned corps of the Public Health Service is a professional career organization of carefully selected, exceptionally qualified physicians, dentists and other members of the Public Health category. It offers regular promotion and rank and tenure comparable to the armed services. Appointments for career service in the regular corps is made from the nationwide competitive examinations, and the successful candidates are usually commissioned in the three lower grades—Junior Assistant, Assistant and Senior Assistant (equivalent to the Navy grades of Ensign, Lieutenant (j. g.), and Lieutenant). Examinations are given periodically. Ordinarily assignments may be made through stations in many parts of this country and possibly abroad. Anyone serving two years of active duty as a Public Health Service Officer is exempted from further training and service under the Universal Military Training and Service Act. Salaries are commensurate with those in the armed services.

Further information as to this particular position may be obtained from Dr. Ball at the State Board of Health.

RURAL HEALTH CONFERENCE TO BE HELD IN ATLANTA

Physicians and farm group representatives from 11 Southeastern states will gather in Atlanta, Ga., Oct. 7-8, for the first regional conference on rural health.

"Joining Hands for Community Health" is the theme of the meeting which will be held at the Dinkler Plaza Hotel and is sponsored by the American Medical Association's Council on Rural Health.

Highlight of the conference will be a banquet address Friday evening, Oct. 7, by Dr. Julian P. Price, Florence, S. C., newly appointed chairman of A.M.A.'s Board of Trustees.

Among the subjects to be discussed at the conference are: Safety—in the Home, at Work, and at Play; Community Planning for Health; Approaches to Preventable Diseases; What's Involved in the Cost of Medical Care.

The Southern Chapter of the American College of Chest Physicians will hold its 17th Annual Meeting at the Statler-Hilton Hotel, St. Louis, Missouri, October 30-31, 1960. All physicians are cordially invited to attend. There is no registration fee.

AMA INDUSTRIAL HEALTH CONGRESS

The Twentieth Annual Congress on Industrial Health will meet in Charlotte, N. C., October 10-12, 1960, sponsored by the Council on Occupational Health of the American Medical Association.

Subjects included on the program include a discussion of occupational health in agriculture, mental and emotional health in industry, problems in dermatitis in farm and industry, and occupational health problems in small employee groups.

Approved for Category II credit for members of the American Academy of General Practice, the program is primarily directed toward the general practitioner, who it is estimated, handles close to 90 per cent of all the occupational medical practice in the nation.

Presiding over the opening session of the congress will be William P. Shepard, M. D., of New York City, Chairman of the AMA Council on Occupational Health.

17th ANNUAL MEETING SOUTHERN CHAPTER, AMERICAN COLLEGE OF CHEST PHYSICIANS

Statler-Hilton Hotel, St. Louis, Missouri

October 30-31, 1960

All physicians are cordially invited to attend this meeting. No registration fee.

FROM THE PRESS

NEW DOCTORS

Licensing of 55 physicians to practice in South Carolina, announced in Monday's News and Courier, is an important news story. It is important because these men will be leaders in their communities. They will bring babies into the world, care for the suffering and ease the last hours of old people.

Much of their work will consist of the sort of medical and surgical techniques they learned in laboratories and operating rooms. But their duties won't end with the use of a scalpel or administration of drugs. Physicians are called on to advise patients on emotional and family problems. For this task, they need to be not only intelligent, but kind and wise. Because medical care can be expensive, they will have to be able to offer practical advice.

Beyond all this, South Carolina's newest doctors will be asked to work in their communities for many good causes. They will be needed to guide civic enterprises. If they live up to their opportunities and responsibilities, the years ahead will be physically

and mentally demanding. But the sense of achievement should be a great reward.

We wish for these physicians strength and wisdom as they begin careers of service to fellow citizens.

Charleston News and Courier

NURSES VOTE DOWN ANTI-FORAND MOVE

The American Nurses Association failed to adopt a Georgia resolution against the Forand bill (HR 4700) despite strenuous efforts by the Georgia and Iowa delegations to the ANA annual meeting to win its approval.

The resolution was given the ANA House of Delegates for a vote after the ANA's Committee on Resolutions had at first refused to accept it on grounds it was in conflict with a previously-approved principle on legislation.

However, the ANA Board of Directors gave permission for its presentation to the House, where it won the votes of approximately one-third of the delegates.

AMA News

DEATHS

DR. L. L. GREGORY

Dr. L. L. Gregory, 88, died at the Sunny Acres Rest Home recently. He had been in declining health for several years.

He was born Sept. 12, 1872, in Kershaw County. After graduating from The Citadel he taught in the public schools for several years before entering the South Carolina Medical College, from which he was graduated in 1900, and practiced in the Pinewood and Paxville communities for many years. In his later years he practiced in Marion, making a total of over 50 years of practice in the state.

DR. HOMER S. PARNELL, JR.

Dr. Homer S. Parnell, Jr., of Columbia died May 30th. Dr. Parnell was a graduate of Vanderbilt School of Medicine, 1939. He had a private practice in Greenville, S. C. from 1948 to 1951. For the past year he has been associated with the Veterans Administration Regional Hospital in Columbia.

DR. W. R. BARRON

Dr. William R. Barron, 77, retired physician, died at his home on August 11. He had been in poor health for several years.

He was the first physician to specialize in urology in South Carolina, for a time was chief of staff of the Baptist Hospital and retired from practice in 1946.

He was a native of Manning, attended The Citadel and was graduated from the Medical College of S. C. at Charleston in 1908.

After being on the staff at Charleston's Roper Hospital he practiced at Hendersonville, S. C., briefly, then moved to Columbia to practice with his brother in 1909. He later studied at Johns Hopkins Hospital.

He was a member of a number of national, regional and state medical societies and associations. He also was vice president and a member of the board of directors of the State - Record Co., which publishes the daily newspapers in Columbia.

He had served as a trustee of Columbia Theological Seminary at Decatur, Ga., was a former member of the board of trustees of Presbyterian College, the State Board of Health and the State Water Pollution Control Board.

He was a principal organizer of the Columbia Businessman's Evangelistic Club, later called the Laymen's Club.

DR. ADOLPH RITTER

Dr. Adolph Ritter, 67, died August 2 at his home near Yemassee after an extended illness.

Doctor Ritter was born at Ruffin. He was graduated from pharmacy school in 1918 and operated a drug store in Ridgeland until 1922 when he entered medical school. He finished medical school in 1928 and came back to Ridgeland to practice. In 1930 he founded the Evelyn Ritter hospital and enlarged the hospital in 1933 and again in 1936. In May, 1944, Doctor Ritter, due to failing health, turned the hospital over to the county and the name was changed to the Ridgeland Hospital.

Doctor Ritter then moved to Yemassee where he practiced until retiring.

Another major factor to be considered in mounting an attack on accidents is the existence or absence of specific measures which will prevent a certain type of accident.

For example, there may be widespread community interest in the development of a poison control program, yet there may be little interest in making radical changes in driver-licensing laws.

A local poison control program may have the potential of saving only 5 lives a year, whereas making the requirements for driver licensing much more drastic may have the potential for saving 50 lives a year in the same community.

The first program is much easier for the lay person to understand; it involves no great sacrifice of personal liberty, and it can actually be developed as a part of existing institutions and organizations.

The latter program is much more remotely associated with accident prevention; its beneficial effects are more difficult to appreciate, it involves more deprivation of personal liberty (a license), and hence must await the preparation of the community mind for its fulfillment. This may take many years.

Albert L. Chapman, M. D.,
Public Health Reports 75:630

MORE NEWS

DR. BOYKIN, RETIRING

Dr. Gary L. Boykin has announced his retirement as a practicing physician after 53 years of service to the people of the Lamar section of Darlington County.

Dr. Boykin has for many years occupied a position of leadership as a physician and civic leader.

Dr. Boykin was born in Newman Swamp Community on November 27, 1865. After completing school in Darlington County, attended the University of Nashville (which later became a part of the University of Tennessee). It was there he received his Doctor of Medicine degree. In 1937, Dr. Boykin was asked to return to the University of Tennessee where he was honored by being presented a certificate of accomplishment for 50 years of distinguished medical service.

For two years Dr. Boykin practiced general medicine in Lamar, and then accepted a position as physician at a private hospital in Norfolk, Va. During 1911, Dr. Boykin returned to his home town of Lamar.

Dr. Boykin decided that Lamar needed a small hospital and in 1955 he built one according to the State Board of Health specifications. He operated this hospital for the city of Lamar for five years. As of July 1, 1960, he sold this little hospital to Drs. S. T. Griffin of Florence and L. W. Heriot of Columbia.

Dr. Boykin is a charter member of the Lamar Civilian Club, is now serving as a member of the County Board of Education, and is a charter member and past Post Commander of Lamar Post No. 94 of the American Legion. Active in his Post affairs, he was responsible for the erection of Post No. 94's Club Building. In other affairs, Dr. Boykin belongs to Lamar Lodge No. 287, Ancient Free Masons. He is an active member of the Lamar Methodist Church.

Dr. and Mrs. James E. (Jack) Padgett, Jr., and family have recently moved to Aiken, South Carolina where he has begun the practice of Pediatrics.

After completing his internship and pediatric residency at the Medical Center Hospitals in Charleston, S. C., Dr. Padgett served for two years with the United States Army at Fort Jackson, in Columbia, S. C. During his second year there, he was chief of Pediatric Department.

Dr. Padgett officially opened his office in Aiken at 233 Barnwell St. on July 1, 1960.

ON BOARD

Dr. Hugh E. Vincent, Jr., Anderson physician, who recently was named to the County Board of Health by the County Medical Society as one of its representatives on the body, has assumed his duties in that post.

DR. SPROUSE ON HOSPITAL STAFF

Dr. J. Henry Sprouse, Jr., of Abbeville, has accepted a position on the staff of the Medical College Hospital at Charleston. He joined the staff on July 1, and will serve as an Associate Professor and specialist in anesthesiology.

A native of Abbeville and a graduate of Abbeville High School, Dr. Sprouse received his degree in pre-medical studies at Erskine College. He received his M. D. degree at the Medical College in Charleston and served his internship there. He completed his specialization work in anesthesiology on June 30 of this year.

DOCTORS MAKE PLANS TO OPEN OFFICES

Dr. Griggs C. Dickson and Dr. J. C. Parke, Jr. were in Hartsville recently to make arrangements concerning the joint practice of pediatric medicine which they will open soon.


Dr. Dickson has completed his residency at North Carolina Memorial Hospital.

Dr. Parke is completing his service with the Navy Medical Corps and expects to move to Hartsville in October or November.

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... is a better place
for you and your family
because
you give
the United Way



A LETTER FROM AFRICA

Sanyati Baptist Hospital
Gatooma, Southern Rhodesia
Africa
July 7, 1960

Hunter W. May, M. D.
Greenwood, S. Carolina

Dear Dr. May:

For weeks now I have been trying to take enough time out from being bush doctor to write you a note. In this first month in Africa it seems that I have used everything I saw, did, or was told last summer, a hundred times over. In all seriousness, I am finding that portion of my medical accumen much more practical and workable than much of what I picked up last year at school.

In some ways this is a medical students' dream. There are two American missionary physicians here but one is away on vacation, and the other is in town part of the time making arrangements for the new OB unit, leaving me to run the 80 bed hospital and daily clinic of 30 to 50 patients alone. We provide the only medical care available for 60 to 80,000 Africans (only the men have ever been counted). My first day alone a woman with contracted pelvis that we had considered doing a section on, went into labor, a child came in with protracted vomiting in severe alkalosis, rapidly followed by another child with a piece of cord wedged against one of his turbinates, to add to my confusion in trying to keep up with 73 inpatients and 35 clinic patients that day. When you have to stop and think or read, this makes life a little rushed.

The hospital is 60 miles by jeep road from the nearest white settlement, and our chief clinic point is an additional 40 miles into the bush. We use Land Rovers (English jeeps) almost exclusively to get about. They are quite high and heavy, and manipulate the poor roads and river beds remarkably well, if slowly. Many of our patients must come 60 miles on foot or bicycle. It would be hard to estimate how many of these people die without receiving any sort of medical care.

The shortage of beds is no problem here since practically all of the patients sleep on the floor under their beds anyway. Right now we are just bothered with a shortage of floor space. Our operating room is furnished with equipment donated to the hospital by a Houston hospital that remodeled in 1950. Most of it is adequate except for the operating table, the foot section of which collapsed twice during a single recent procedure. They really have to be sutured back together well here! Somebody gave us a new OB table last year. We have lights for four hours each evening from our diesel generator and try to do all of the surgery then. There is no kitchen. Patients food is provided by their families who camp out behind the hospital, and usually consists of their everyday diet of soda (very stiff grits) and beans. The little meat that they have is allowed to begin decaying before

they cook it. We do have an old fashioned wood stove to heat baby bottles and provide tea for the staff. The electric powered autoclave runs three days a week all day and manages to keep up with instruments and a few linens for surgery. Syringes we re-use all day for the same few medications with a simple change of needles. There is very little hepatitis and everybody has malaria here anyway.

Our lab does hemoglobins, white counts and stools and urines for ova and parasites. At least a fourth of the people here have schistosomiasis, many have hookworm, tapeworm and ascariasis, and all have malaria. We have two American nurses here, an African nurse who is a R.N. equivalent and runs the hospital, and practical nurse equivalents who cover all the shifts.

No free care is provided except for mission employees. We charge the people approximately the cost of their medications. If they cannot pay the bill, they or their family must work it out at the usual wage of a ticky an hour (\$.03). We use only the cheapest practical medicines but they still find our bills high. Having a baby at the hospital costs \$1.25 including a picture for the birth certificate. The total hospital bill for most patients averages about \$1.00 and is almost never over \$2.00. A clinic visit costs \$.06 to \$.50. We use only penicillin and sulfa for antibiotics except in rare cases. Tranquilizers we use heavily because some of the people tend to develop acute schizophrenic reactions when on treatment for schistosomiasis.

TB is very common here. My first week we had two pediatric deaths from tuberculous meningitis. Everyone has it and we can't begin to isolate and treat all of them. That is part of our greatest equipment deficit. Our only x-ray unit is a World War II Army surplus portable, which would never get up but 30 KV. A chest requires a full second exposure, and an abdomen is impossible to penetrate. When we spot TB with that, they really have it; and to complicate matters, our homemade table must double as morgue, etc.

Please tell everyone hello for me.

Sincerely,
Bob Faulkner



Photo by E. S. Powell

A bit of the banquet.

ONE HUNDRED AND TWELFTH ANNUAL SESSION SOUTH CAROLINA MEDICAL ASSOCIATION

MAY 17, 18, 19, 1960

OCEAN FOREST HOTEL

MYRTLE BEACH, S. C.

MINUTES CONTINUED HOUSE OF DELEGATES

Wednesday, May 18, 1960 — 9:30 A. M.

Presiding—President William Weston, Jr., M. D.

THE CHAIR: The meeting of the House of Delegates will come to order. We will hear from the Chairman of the Credentials Committee, Dr. R. L. Sanders.

DR. SANDERS: We have a quorum, sir.

THE CHAIR: How many delegates are there, Dr. Sanders?

DR. SANDERS: Forty-six members present, sir.

THE CHAIR: How many delegates are there, altogether?

DR. SANDERS: Ninety (90) sir, and we have 9 past presidents.

THE CHAIR: There is a quorum present so the meeting is officially called to order. If any of you have announcements which you would like to be made I would appreciate your writing them out so that I can read them and I will be glad to make them.

This is certainly not a good representation with 90 odd delegates and only 46 present. I think we should take our work a little more seriously.

I will ask you to announce your name, the county which you represent and if a past president say a past president and use the microphone.

Dr. Guess gave the invocation yesterday and as stated I invited two ministers and I tried to get in touch with a third one this morning, but they are evidently vacationing or somewhere else, so we will not have any further invocation.

I will call on the Chairman or the Acting Chairman of the Memorial Committee, Dr. Goldsmith.

MEMORIAL COMMITTEE

DR. THOMAS G. GOLDSMITH, Greenville:

Mr. President, Members of the House of Delegates, as is our custom we come together at this time to honor the memory of those friends and colleagues who have departed this life since our meeting a year ago. The following past members of the South Carolina Medical Association have died within the past twelve months:

"The lives these men have lived speak plainly to those who knew them well — and we can honor them best by the lives we continue to live. As expressed by Thomas A. Kempis, "A life without a purpose is a languid, drifting thing—Every day we ought to renew our purpose, saying to ourselves: This day let us make a sound beginning, for what we have hitherto done is nought.—Our improvement is in proportion to our purpose.—We hardly ever manage to get completely rid even of one fault, and do not set our hearts on daily improvement.—Always place a definite purpose before thee."

Submitted by the Memorial Committee

Signed: Dr. Martin M. Teague, Chairman

Dr. Thomas G. Goldsmith

Dr. E. Kenneth Aycock

At this time I would like for you to please stand in silent prayer for a moment. (The convention stands)

THE CHAIR: Thank you very much, Dr. Goldsmith. Is there any report from the Credentials Committee?

DR. CHARLES O. BATES	Greenville	1959
DR. L. KENT BEST	Charleston	Jan. 19, 1960
DR. CHARLES BOLT	Anderson	Jan 9, 1960
DR. ARCHIBALD J. BUIST, JR.	Charleston	Apr. 21, 1960
DR. JAMES WILLIAM DAVIS	Clinton	Nov. 4, 1959
DR. EUGENE B. GAMBLE	New Zion	July 22, 1959
DR. THOMAS B. HARPER	St. Stephen	Jan. 6, 1960
DR. JUDSON A. MILLSAUGH	St. George	Mar. 4, 1960
DR. GEORGE T. PEEL	Anderson	1959
DR. WALKER H. POWE, SR.	Greenville	May 24, 1959
DR. LUTHER A. RISER	Columbia	March, 1960
DR. CHANDLER W. SCOTT	Hartsville	June 14, 1959
DR. JAMES EDWARD SCOTT	Charleston	June 29, 1959
DR. JOHN C. SEASE	Little Mountain	Dec. 31, 1959
DR. JAMES A. THOMASON	Fountain Inn	Sept. 25, 1959
and his son		
DR. EUGENE A. THOMASON	Fountain Inn	Feb. 25, 1960
DR. WALTER H. WATSON	Greenville	Aug. 15, 1959
DR. I. RIPON WILSON	Charleston	June 14, 1959
DR. CLAUDE H. WORKMAN	McCormick	Nov. 15, 1959
DR. MASON P. YOUNG	Anderson	Feb. 6, 1960
DR. CHARLES P. VINCENT	Laurens	Dec. 5, 1959
DR. WM. E. SIMPSON	Rock Hill	
DR. HAROLD B. WEBB	Camden	

DR. SANDERS: We have had about 10 more come in, Dr. Weston.

THE CHAIR: Thank you.

I have asked the men on the credentials committee to assist Dr. Barney Timmons, the Sergeant-at-Arms and his committee with the collection of votes in order to conserve time.

REFERENCE COMMITTEE REPORTS

THE CHAIR: The first report is that of Reports of Council and Officers, Dr. O. B. Mayer, Chairman.

REPORT OF COUNCIL AND OFFICERS

(1) DR. O. B. MAYER (Recognized) Mr. President, members of the House of Delegates, (Reading)

"The Reference Committee on Reports of Council and Officers considered the following reports and make the following recommendations to the House of Delegates:

"(1) We move the adoption of the Treasurer's report as read and congratulate him on the excellent financial condition of the Association. This committee recommends that Council consider the question as to whether greater interest and better understanding by the House of Delegates would be served by a more complete breakdown of the Treasurer's report."

Mr. President, I move the adoption of the recommendation. (The motion was seconded)

THE CHAIR: You have heard the motion made and seconded, what is your pleasure? (The motion was put to a vote and passed.) It is so ordered.

Dr. Mayer continues report—

"(2) We move the adoption of the Secretary's report as read and congratulate him on the handling of the Association's affairs." I so move, Mr. President. (This motion was seconded, voted on and passed and it was so ordered.)

Dr. Mayer continued report—

"(3) We find the Executive Secretary's report informative, complete and satisfactory and we move its adoption as read."

I so move, Mr. President.

(This motion was seconded, voted on and passed.)

"(4) After study of the president's detailed report of his activities the Committee realizes the president's office is becoming more involved and requiring more of his time and talents. The Committee wishes to congratulate and thank Dr. Wm. Weston, Jr., for the successful year that has passed and we move that the report as presented be adopted." I so move, Mr. President. (This was seconded many times from the floor, there was no discussion, the vote was taken and it was passed.)

"(5) The committee moves the adoption of the report of Dr. J. I. Waring, Chairman of Medical Advisory Committee to the Crippled Children Society of South

Carolina and we wish Dr. Waring continued success in his endeavors."

I move its adoption, Mr. President.

(This was seconded, there was no discussion, the vote was taken and it was passed.)

"(6) We reviewed the report of Dr. J. I. Waring, Editor of the Journal and commend him on the progress and success of the State Journal and move the adoption of his report."

I so move, Mr. President. (This motion was seconded, there was no discussion, the vote was taken and it was passed.)

"(7) We found the report of Dr. William Weston, Jr., Delegate to the A.M.A. most interesting and complete; we congratulate him on his interest and activity and move the adoption of his report as read."

I so move, Mr. President. (This motion was seconded) (Dr. Weston asks Dr. Evatt, Vice-President to take the Chair.)

DR. EVATT (Presiding) It is moved and seconded, is there any discussion? (There was none, the vote was taken and the motion passed.) It is so ordered.

(Dr. Weston resumes the Chair.)

(Dr. Mayer continues his report)

CIVIL DEFENSE

"(8) Dr. Charles N. Wyatt, Chairman of Council presented several recommendations to the House of Delegates. Para. 5 of his recommendations being referred to our committee as follows:

"Council feels that the Medical Director of Civil Defense should be a continuing job and recommends that the plan as now prevails should be changed so that the president and the president-elect are relieved of this duty as Medical Director and Deputy Medical Director, respectively, and a member of this association be elected by Council to serve in this capacity."

Our Reference Committee recommends to the South Carolina Civil Defense Commission that the president and president-elect of the S. C. Medical Association serve as ex-officio members of the S. C. Civil Defense Agency and that the Office of Medical Director and Deputy Medical Director be filled by recommendation of Council to the Director of the State Civil Defense Commission, and we so move.

(This motion was seconded)

THE CHAIR: Is there any discussion of this motion?

DR. P. F. LaBORDE, JR., Columbia: (Recognized) That particular aspect of this came up also in the Miscellaneous Committee Business, referred to us, and we have a recommendation which is not essentially greatly different but perhaps it would be well that our chairman be allowed to present that portion of our report of the same thing since it was referred to our committee.

THE CHAIR: That was Miscellaneous Business, Dr. May would you like to speak on that now? This is under discussion of this motion.

DR. CHARLES R. MAY, Chairman, Reference Committee on Miscellaneous Business. (Recognized)

Mr. President and members of the House of Delegates, this portion of the report was referred to us, possibly inadvertently, I don't know how it got to us, but we made this recommendation, and this is the report on Civil Defense. (Reading)

"We recommend that the report be accepted as information, but in accordance with recommendation made from the floor we recommend that the head of the Medical Civil Defense be appointed by the president for a term of office not less than three (3) years." There is not a great deal of difference between our recommendation and the motion before you, and I think it makes no difference which one is accepted. We move this adoption, however, and we can take it as information in our report and go along with this.

THE CHAIR: Well, the point of difference that I see



Photo by E. S. Powell

Meeting of the Advisory Committee to the Crippled Children Society.

Dr. May is that in one Council is responsible and the other the president is responsible and he appoints for three years and he is not to serve but one year as president. I believe it would be better to put the responsibility on the Council. That is my own opinion. DR. MAY: I believe my committee would accept this change and simply strike this report from our record. If my committee has anything to the contrary if they will say so we will talk about it, otherwise we will strike this portion from our report.

DR. ROBERT S. SOLOMON, Moncks Corner: Will I be out of order to hear that report again, I came in late.

THE CHAIR: Certainly, Dr. Mayer will you reread that?

DR. MAYER: (Reading) "Item No. 8."

First I will state that Recommendation No. 5 of Dr. Chas. N. Wyatt's report as Chairman of Council was referred to my committee, which is the Reference Committee on Reports of Council and Officers, and that recommendation was as follows:

"Council feels that the Medical Director of Civil Defense should be a continuing job and recommends that the plan as now prevails should be changed so that the president and the president elect are relieved of this duty as Medical Director and Deputy Medical Director, respectively, and a member of this Association be elected by Council to serve in this capacity." And the Reference Committee made the following change.

"Our Reference Committee recommends to the South Carolina Civil Defense Commission that the president and president-elect of the S. C. Medical Association serve as ex-officio members of the S. C. Civil Defense Agency and that the office of Medical Director and Deputy Medical Director be filled by recommendation of Council to the Director of the State Civil Defense Commission, and we so move."

In other words, it is the Director of the State who has the power to appoint. We are simply putting ourselves in a position to suggest to him a person to represent the South Carolina Medical Association.

THE CHAIR: Recognizes Dr. Wyatt.

DR. WYATT: That is the most interest I have seen in Civil Defense in this group since the thing has been going on. I would like to talk for the recommendation as made by the Reference Committee. As you so stated the president only serves for one term, one year, therefore, I think it should be left in the hands of Council to nominate this man and to see that he serves as long as he serves efficiently or as long as he wants the job.

THE CHAIR: Thank you, Dr. Wyatt. Is there any further discussion?

DR. MAYER: Do you need another motion for the adoption of this?

THE CHAIR: Your recommendation is the motion. Do I hear a second to his recommendation? (This was seconded by Dr. Wyatt.) Is there any further discussion? If not the motion shall be put, all in favor of the reference committee's report in regard to Civil Defense please signify by the usual sign. (The vote was unanimous.) It is a motion.

DR. MAYER: That concludes the report and I move the report be adopted as a whole. (This was seconded, there was no discussion, the vote was taken and it was passed and so ordered.)

THE CHAIR: The Second report is that of the Reference Committee on Legislation & Public Relations, Dr. Frank C. Owens, Chairman.

(2) DR. FRANK C. OWENS (Recognized by The Chair) Mr. President and gentlemen, (reading)

PUBLIC RELATIONS

"The reference committee on Legislation and Public Relations considered the following reports and make



Photo by E. S. Powell
Howard Stokes and Jack Meadors contemplate a certificate.

the following recommendations to the House of Delegates:

1) We move the adoption of the report of "Public Relations Activity" and recommend that the program be continued on the same basis as last year."

By way of explanation, this is the program that Dr. Joe Waring outlined to you yesterday in relation to the public relations activity. (This motion was seconded by Dr. Cain, there was no discussion, the vote was taken and it was passed unanimously.)

THE CHAIR: It is a motion.

Dr. Owens continues report:

"2) Dr. George Dean Johnson recommended that the Greenwood Medical Society and Dr. P. L. Bates be congratulated for their letter to Mr. Forand on "Medical Care of the Aged" and that this letter be given further publicity. In accordance with this recommendation our committee moved that the letter be referred to Dr. Joe Waring with the request that it be published in the S. C. Medical Journal when space permits." We move the adoption of this. (This motion was seconded by Dr. Gaines and others, there was no discussion, the vote was taken and it was passed unanimously.)

THE CHAIR: It is a motion.

Dr. Owens continues report:

"3) We move that the report of the State Board of Medical Examiners be accepted as information." (This was seconded by Dr. Wilson, there was no discussion the vote was taken and it was passed.)

THE CHAIR: It is a motion.

Dr. Owens continues report:

"4) We move that the report of the Committee on liaison with Allied Professions be accepted as information. (This was seconded, there was no discussion, the vote was taken and motion passed.)

THE CHAIR: It is a motion.

Dr. Owens continues report:

KEOGH-SIMPSON BILL

"5) In the report of the Chairman of Council, Council recommended the approval of the Keogh Bill and that the House of Delegates so notify their representatives in Congress to that effect. Our Committee concurs in this recommendation and moves its adoption." (This motion was seconded by several from the floor.)

THE CHAIR: The last I heard of this bill, now under discussion, it was the Keogh-Simpson bill; and it used to be the Keogh-Jenkins Bill, and I don't know if it ought to be left as "Keogh Bill" alone, or not. Maybe Mr. Meadors could inform us as to that. Do you know, Dr. Johnson?

DR. JOHNSON: I think it is just the Keogh Bill, Mr. Simpson is not in the House. I think it is just the Keogh Bill, it makes no difference, everybody knows what you are talking about.

THE CHAIR: Is there any further discussion?

DR. HANCKEL: (Recognized) I would like to ask if it didn't have a number on that?

DR. OWENS: There was no number listed on the notice sent to the Committee, it was just the Keogh Bill.

THE CHAIR: Is there any further discussion? (There was no further discussion, the vote was taken and passed.) It is a motion.

Dr. Owens continues report:

"6) The Committee moves that the report of the Committee on Welfare and Rehabilitation be accepted as information." (This was seconded, there was no discussion, the vote was taken and it was passed.)

THE CHAIR: It is a motion.

Dr. Owens continues report:

"7) We move the report of the Chairman of the Executive Committee of the State Board of Health be accepted as information. The Committee also recommends that the House of Delegates express their sympathy to the family of the late Dr. Vivian Platt, Sr., member of the State Board Executive Committee, who recently passed away."

Dr. Platt passed away recently having served as a representative of the Pharmaceutical Association for a number of years on the Executive Committee of the State Board of Health, therefore we feel it proper that this House of Delegates express their sympathy to his widow. We move the adoption of this report and the sending of a message of sympathy to Dr. Platt's family. (This was seconded; there was no discussion; the vote was taken and it was passed.)

THE CHAIR: It is a motion, and the letter will be written.

Dr. Owens continuing report:

"8) No report was received from the Committee on Industrial Medicine."

The report was referred to our committee, however the Committee on Industrial Medicine did not meet in the past year and no report was rendered.

"9) The Greenville Medical Society submitted the following resolution:

MOTION ON FEDERAL SPENDING

"RESOLVED, by the Greenville County Medical Society this third day of May, 1960, that it petition the United States Congress to refrain from embarking upon new federal spending programs in any field whatsoever including federal aid to education, federal aid to state, and municipal governments, federal aid to various "needy" segments of the population, federal aid to foreign governments, and in particular federal practice of medicine, and, request that the State Medical Association adopt a similar resolution."

Our committee recommends substitution of the following:

"Be it resolved, that the Federal Congress be urged to adopt a very much more conservative attitude in its expenditure of public funds and that a copy of this resolution be sent to the South Carolina Senators and Congressmen."

We move the adoption of the substitute resolution. (Seconded)

THE CHAIR: You have heard the substitute motion made by the Reference Committee, made and seconded, is there any discussion?

DR. TOM PARKER, Greenville (Recognized by The Chair):

Mr. President and delegates, the committee was kind enough to let me speak to them last night while they were discussing this resolution. It was my feeling while they were talking that it was the opinion of



Photo by E. S. Powell

Tom Parker, surprised.

various members of the Committee that as physicians and as private citizens we were not qualified to express opinions upon the serious matters which involved Federal policy, both domestic and foreign, and therefore they have brought back a resolution in very general terms to the effect that we ask the Congress to go easy on its expenditures.

Now, I would like to submit to your consideration the thought that the original resolution as submitted by the Greenville County Society is very simple in its concept. The concept is this, that the Federal Government is head over heels in debt, which it is—and second that we therefore ask the Federal Government not to go into any new programs of Federal spending, not to increase its sphere of activities and the wording of the original resolution, as Dr. Owens read it was as follows: (Reading)

"That we petition the United States Congress to refrain from embarking upon new Federal spending programs" Now, I submit to your consideration that this concept is very simple and there is nobody in this room who is not able to understand the principle involved. Now, we often take the position that these are highly technical matters and that we are not able to advise our congressmen, that they are much better informed on this matter. Now, it is my serious opinion that the men of the United States Congress are people who, by their own choice,—nobody makes them run for Congress,—that by their own choice are public servants and that they suffer great personal sacrifice in order to run for Congress. Nevertheless their thoughts are not always completely devoted to what is best for the people because they must devote considerable time and effort to the thought of what will secure their own re-election. And of course this takes considerable time and effort.

It is certainly the duty of the Citizens of the United States and the doctors in particular because doctors are not only citizens they are highly educated citizens and they are looked upon as leaders in their respective communities. And it is the duty of citizens and of doctors in particular to take stands upon moral issues. They have to take stands upon moral issues or else forfeit their moral integrity. Therefore, I would say that since the concept involved is simple, and we all understand it, the Federal Government is in debt; we do not wish it to embark upon new spending programs. We have not asked them to abandon what they are presently doing, we have not asked them, for example to do away with income tax—we have only asked them to quit spending more money in new fields. Now, that is very different indeed to the resolution which has been submitted by your Reference Committee.

(Substitute Motion) Therefore, I would like to move as a substitute Motion that this House approve the resolution which was submitted by the Greenville County Medical Society, and I so move.

(This motion was seconded by Dr. Goldsmith)

THE CHAIR: The motion made by Dr. Parker and seconded by Dr. Goldsmith is a substitute motion for that brought out by the Reference Committee. Is there any discussion? (Dr. Owens is recognized.)

DR. OWENS (Chairman of the Reference Committee)

At our committee meeting last night we had a most interesting discussion of this entire thing. Dr. Parker brought out some very fine points and various members of the committee brought out many points in favor and against the points in this Greenville Medical Society resolution. In general it was felt by the most of the committee that from a theoretical standpoint we heartily approved of the concept expressed in the Greenville Society's resolution. But, from a practical standpoint we didn't feel we had enough information to warrant recommending the passage of this. For instance, in foreign aid, most of us feel that we shouldn't be spending so much money abroad but we don't know what situation might arise that would make it very necessary for this country to spend some money abroad and we felt the people in Washington, who had the real inside on this were in better position to know how to act on that than we do.

Some of us also felt that the roads system, the Board of Health, hospitals, various departments of the Government receive certain aid from the government, the state government receives aid from the Federal Government and there would be new programs coming up, for instance on radio-activity, for which the Federal Government would probably advance money to the State, and this resolution would express probably our belief that that should not be done. So, we wanted to go along, in fact we wanted to support the general concept that the Federal Government should be conservative in their spending but we felt that to spell it out, the way that this resolution does, would not be advisable at this time.

DR. GOLDSMITH (Recognized by The Chair): Mr. President, members of the House of Delegates, I feel that a good many people in the state and in the nation do not realize that there is no such thing as Federal aid. It has to first come from the taxpayers pockets and if we could hold down what the Federal government takes away from us and then dribbles back to us we would be doing our citizens a service.

The matter of foreign aid, etc., that has been mentioned in this, are specific items and I have talked to senators and I have written to our congressmen and senators and all in South Carolina and other states and they appreciate and expect just such information from the grass roots. Too many of us forget we are first citizens, we are citizen doctors and as citizen doctors we are entitled to express our opinion on any national, state or local legislation. As I mentioned a minute ago, there is no such thing as Federal aid. The figures for 1958 are the last figures I have available and the amount of Federal income tax that went from South Carolina and the amount that was returned to South Carolina in all forms—that is grants, etc., and so on that they sent back here was less than thirty (\$0.30) cents out of each dollar that went to Washington. Now, gentlemen that is a high brokerage fee and this goes on all over the country and the congressmen and senators appreciate information and suggestions from their constituents, and I would like to see the original motion passed.

(Request was made from the floor that the resolution as submitted by the Reference Committee be read again.)

THE CHAIR: The request is made that you re-read

the resolution as submitted by the Reference Committee, Dr. Owens.

DR. OWENS: (Reads) "*Be it resolved*, that the Federal Congress be urged to adopt a very much more conservative attitude in its expenditure of public funds and that a copy of this resolution be sent to the South Carolina Senators and Congressmen."

DR. HAROLD S. PETTIT (Charleston) (Recognized by The Chair) Mr. President, I move the substitute motion be tabled. (This was seconded by Dr. Hanckel.)

THE CHAIR: The motion is made that the substitute motion be tabled, seconded by Dr. Hanckel. There is no discussion of a substitute tabling motion. I will ask the tellers to please get busy. Those in favor of tabling the substitute motion please rise. (The count is taken)

THE CHAIR: Those opposed to tabling the motion, please rise. (The Count is taken by the tellers.)

The vice-president has informed me he thinks some of you might be confused. You are voting on tabling the substitute motion. May I hear from the Sergeant-at-Arms?

DR. TIMMONS: (Sergeant-at-Arms) thirty-eight (38) opposed, twenty-seven (27) for.

THE CHAIR: The motion for a tabling was not passed. (Someone from the floor stated it was passed.) It was not passed.

The Chair is going to rule since there are plenty of chairs in the beginning those behind the tables will not be counted. You have plenty of room up here, and that is what they are put here for. So, from now on if you want to be counted you will have to be up here at the table. Now, if there is an overflow, then you can use the first seats in the rear.

DR. JOHNSON (Recognized by The Chair): I want to thank you for that constructive move. There is one thing I would like to point out and this is speaking for either resolution. Last year the Federal personal income tax from South Carolina was \$232,000,000.00. Above that \$52,000,000.00 corporation tax; the State Income Tax \$30,000,000.00.

THE CHAIR: Thank you, Dr. Johnson.

DR. JOE CAIN (Recognized): We voted down the substitute motion which was the original resolution and . . .

THE CHAIR: (Interrupting) No, wait a minute, the motion to table the substitute motion did not pass. (Some from the floor call out "it did pass".)

DR. CAIN: Mr. President, will you please have them vote again, there seems to be so much misunderstanding about how the vote was. Some of them at the back of the room were not counted properly and I think in fairness to all it should be taken again.

THE CHAIR: We will vote again on the tabling of the motion, there is no discussion, there seems to be considerable movement but there will be no discussion of tabling the motion.

DR. NORMAN O. EADDY: (Recognized by The Chair) Mr. President, will you make it clear what motion they are voting on?

THE CHAIR: We are voting on the tabling of the substitute motion.

Question from the Floor: Who made the substitute motion?

THE CHAIR: Dr. Parker made the substitute motion and it was properly seconded by Dr. Goldsmith, both of Greenville, S. C., is there any question of their proper delegation? The motion to table was made by Dr. Harold Pettit of Charleston and was seconded by Dr. Hanckel. There is no discussion.

(A doctor from the floor) Point of order. From the people around here I can tell that many of us are not sure exactly what is to be voted on, what was the substitute motion, to table the original motion,—what was the original motion?

THE CHAIR: The original motion was Dr. Parker's motion from Greenville—do you want that re-read? The motion is that we table the substitute motion.
DR. PETTIT: (Charleston) Point of order. The motion was to table the substitute motion and leave the original motion on the floor.

THE CHAIR: That is what I said, The motion to table the substitute motion.

DR. JOHNSON (Recognized by The Chair): The original motion was the one that Dr. Owens made, as far as the Reference Committee is concerned. The substitute motion is the one that Dr. Parker made. We are not considering the motion that went to the reference committee but we are considering the motion that came out of the Reference Committee and that is the original motion by Dr. Owens. The substitute motion is Dr. Parker's.

THE CHAIR: That is right.

(A doctor from the floor) This is part of the discussion, but wouldn't it clarify matters to say that if we are voting to table we are voting for Dr. Frank Owen's Reference Committee motion, if we are voting not to table we are voting for Dr. Parker's original Greenville County Medical Society resolution.

THE CHAIR: Well, if you want to explain it that way, but we are not voting on Dr. Owen's motion yet. We are voting on the substitute motion. The motion is that we table the substitute motion and it has been duly and properly seconded.

(The question is called for by Dr. Wilson)

THE CHAIR: All those in favor of tabling the substitute motion please rise and remain standing until you are counted. All opposed please rise and remain until you have been counted.

DR. SANDERS: Mr. President they voted 39 (thirty-nine) to table, forty (40) against tabling.

THE CHAIR: Thirty-nine (39) in favor of tabling and Forty (40) against. The motion to table is lost. Now we vote for the substitute motion.

DR. CAIN (Recognized by The Chair) Mr. President I would like to discuss this a minute. Gentlemen, it seems to be the temper of the house of delegates that we want to pass something that is a whole lot better. With no reflection on the committee, I think it was a rather weak-kneed resolution that the Reference Committee brought in. Even though we voted against tabling the substitute motion, a lot of us feel the other one is too strong, there are certain points which they brought out which we feel might throw the Association in a bad light. For instance, we are against care for the needy. That can be interpreted any sort of way anybody that reads it wants to put on it.

(Motion) I would like to make a motion that we ask Dr. Parker to amend his substitute motion—I would like for him to amend his original resolution so that it can be brought more in line with what some of the others of us think. We are sort of in between, and we don't want to have to have a choice of voting against something or for the other, either one of the choices.
THE CHAIR: Dr. Parker, will you accept the amendment?

DR. PARKER: Please understand, this is not my motion, Mr. President. This is a motion of the Greenville County Medical Society and I am only a delegate, so I am not authorized to speak for the County Medical Society. Nevertheless, if I understand Dr. Cain correctly, what he objected to was one particular phrase, and that phrase being "Federal aid to various 'needy' segments of the population" and as far as I am personally concerned, in order that we may get along and clarify our thinking, as far as I am personally concerned I would accept as an amendment this one phrase "Federal aid to various 'needy' segments of the population." That is what you wish, Dr. Cain? As far as I am concerned I will accept that amendment.



Photo by E. S. Powell
Dr. Askey addresses the meeting.

DR. HANCKEL: I wonder would Dr. Parker be willing to read the motion, now, with that eliminated?

DR. PARKER: You want me to read the whole motion?

DR. HANCKEL: No, just that part of it.

DR. PARKER: All right. The preamble, as you know, is to the effect that the Federal Government is head-over-heels in debt. The motion then is: "Resolved, by this Association that it petition the United States Congress to refrain from embarking upon new federal spending programs in any field whatsoever including federal aid to education, federal aid to state and municipal governments, federal aid to foreign governments, and in particular federal practice of medicine."

DR. GOLDSMITH: As original seconder of the motion I accept the amendment.

THE CHAIR: The amendment has been accepted and seconded, is there any discussion?

DR. THOMAS R. GAINES, Anderson: Mr. President, it appears that this motion is rather broad. I would like Dr. Parker to read once again that statement where he asked the Federal Congress not to appropriate any money to any new field whatsoever. It appears to me the South Carolina Medical Association is going a little far of our duties as an association or I think we are going a little far from our duties as individuals, as individual citizens to ask the Federal Congress not to appropriate any funds to any new fields of endeavor.

THE CHAIR: The Chair certainly thinks that what Dr. Gaines just said is correct, and I can't see to save you how you can prevent Congress, and I think we would be belittling ourselves, from appropriating money to go to Mars or Venus or anywhere else, and there are other things besides missiles and we are not in that kind of research and I think we are just off base. I just think to ask Congress to do a thing of that kind is a little poor for us.

Is there any further discussion?

DR. THOMAS PARKER (Recognized by The Chair): Mr. President, I apologize for speaking so much and I am speaking only to answer Dr. Gaines' question. This motion is aimed at what we loosely call "welfare programs". As you know under Mr. Eisenhower the Federal budget has reached limits that have never been reached before and this is not because military expenditures have gone up, because they have gone

down, even though we are in the midst of this cold war. It is because so-called social welfare programs have gone up and they come in various fields, such for example as the National Education Defense Act, which is designed to train students for physics and such but actually also to train them in the dramatic arts and cooking and things like that. I think that what Dr. Gaines has in mind would be a wording having to do with federal expenditures, federal spending programs in so-called social welfare fields. Now, again you get into matters somatic but also if you are talking about the possibility of appropriating money for missiles or for flight satellites—those are not new programs. We have got to appropriate money for them. You even take air pollution, which is certainly medical, that is not a new program, the amount of money for that will be appropriated from year to year. But this resolution would not prevent Congress from appropriating money for air pollution or appropriating money for missiles, or space satellites, or for undersea work, and all sorts of things but it would prevent them from entering into new social welfare programs. We are begging them not to look for ways to spend money for allegedly humanitarian programs. DR. OWENS (Recognized by The Chair:) Mr. President, may I discuss this for just another minute, please. In general I think we all agree that we don't want the congress to be spending money that they should not be spending, but this resolution, I believe, goes a little bit too far. It says "from embarking upon new federal spending programs in any field whatsoever." Does that mean that we want our government to stand still and not do anything new? Suppose you were to petition the Columbia, Greenville or Charleston City Council not to undertake any new programs. I don't think that would be very realistic. We are asking them not to appropriate anything for a new program. They are building a dam that will cover all this area at Clemson, around the college and all up in there and the question of waste disposal is a big one and some of those communities can't afford to build the disposal plants with their own money. I think practically all of those in that area are going to get the federal government to aid them in building their disposal plants. That is a new program, in a way, and it might have to be passed by Congress before they can get it. But things come up every day, new things, and I don't believe we should go as far as this goes. Now this resolution, as submitted by the Reference Committee, I thoroughly agree it is a watered-down resolution but it was the best we could come up with at this time to express the fact that we do not think congress ought to be throwing our money away, but I do feel that Dr. Parker's resolution goes too far, it is not realistic and is not in accord with the situation as it really is.

DR. GOLDSMITH (Recognized by the Chair)

THE CHAIR: Dr. Goldsmith, we must limit the discussion here, there is only three times for each man.

DR. GOLDSMITH: Mr. President, I would like to make a substitution right here in this wording—where it says "new federal spending programs in any new field whatsoever" to just say "any new federal spending programs in the social welfare field. One other thing you must know is that any suggestion we send to congress isn't enacted into law right away, anyway. (Laughter)

THE CHAIR: If you don't think you have got any influence there is no use to do it. (laughter) I think we ought to be serious about this matter and if we are going to stop all federal spending why we have got another thought coming, regardless of what resolution we pass and we can't stop research in any organization. Now, we have got two amendments. He accepted the first amendment—is there a second to the second amendment? Dr. Goldsmith seconded

the original substitute motion and has accepted the first amendment, now this is the second amendment. (Dr. Parker seconds Dr. Goldsmith's amendment.) Is there any further discussion?

(From the floor) Call for the question.

THE CHAIR: Is there any discussion?

DR. R. S. SOLOMON, Moncks Corner: (Recognized) Mr. President, I move the motion as amended be tabled.

DR. GEORGE G. DURST: I second the tabling motion.

THE CHAIR: You second the table? The motion is that the amendment be tabled and it has been duly seconded. Will the tellers please get to work. All those in favor of tabling the amendment please rise.

From the Floor: Is this a vote on the amendment or a vote on the substitute motion.

DR. SOLOMON: The motion as amended.

THE CHAIR: The motion as amended, you are voting on the whole thing, then. The substitute motion as amended.

DR. LIDE: Is this Dr. Parker's motion we are tabling?

THE CHAIR: Do you understand that, this is the motion from Greenville County which is the substitute for the Reference Committee. Now, you are voting on it to be tabled. If you vote *for* you are voting to table the substitute motion. (The vote is counted by the tellers.) Those opposed, please stand. I don't think there is any doubt about that.

DR. TIMMONS (Sergeant-at-Arms) 31 (thirty-one) to table, forty-four (44) opposed to tabling.

THE CHAIR: Now we have the original substitute motion as amended and amended. We will have to vote on the second amendment. Those in favor of Dr. Goldsmith's amendment—he substituted "any new federal spending programs in the social welfare field"—that will now be voted for. Those in favor of this amendment please signify by rising. (So many rose that the Chair announced that the amendment has passed.)

Those in favor of the second amendment which was made and seconded, please rise. (Delegates stand)

The Chair rules it is not necessary to count, as I have eyes and can see. (laughter) Those opposed please rise. (none rose).

Now, those in favor of the substitute motion as amended and amended, please rise. I will ask the tellers to count this one. (Those standing are counted.) Those opposed please rise. (They are counted.)

DR. TIMMONS: (Sergeant-at-Arms) Fifty-three (53) for, twenty-eight (28) opposed.

THE CHAIR: The substitute motion has passed. (applause)

DR. OWENS: Chairman of Ref. Committee on Legislation and Public Relations: I move the adoption of the report of the committee including the last substitute resolution as amended. (This was seconded, there was no discussion, the vote was taken and unanimously passed.)

THE CHAIR: It is a motion.

I have a couple of announcements I would like to make. We would like very much to welcome Dr. R. M. Holcomb of New Milford, Pa., if he will please stand and be recognized. We are glad to have you (applause) and Dr. James Davis of Greensboro, North Carolina, who is executive secretary and treasurer of the Tri-State Medical Association. Dr. Davis, if you will stand. (applause) We are delighted to have you and if either of you have anything constructive to offer we would be glad to have it, rather than destructive, as is taking place up here. (Laughter)

Dr. Roderick Macdonald has called a meeting of the Mediation Committee immediately after adjournment in this room. That is the same thing as the Grievance Committee, if you want another name for it.

There is also a beer party sponsored by the Medco

Inc., on the shuffleboard court, right out here on the ground floor, at 12:00 o'clock or just as soon as we get through.

Are there any further announcements at this time before we proceed with the next report? (There were none)

THE CHAIR: The fourth report we will hear is that of the Reference Committee on Amendments to the Constitution and By-Laws, Dr. Wyman King, Chairman, of Batesburg.

(4) DR. WYMAN KING, Chairman (Recognized by the Chair): Mr. President and Members of the House of Delegates, the Reference Committee on Amendments to the Constitution and By-Laws had only three items before us for consideration.

CERTIFICATION OF PSYCHOLOGISTS

1) The first item was the report of the Committee on Certification of Psychologists, Joe E. Freed, Chairman. We recommend the approval of the report as published and I so move. (This was seconded, there was no discussions, the vote was taken and it was carried.)

THE CHAIR: It is a motion.

(Dr. King continues report)

HISTORICAL COMMITTEE

2) The second was the report of the Committee on Historical Medicine, Joe I. Waring, Chairman, which includes a request for an additional Five Hundred (\$500) Dollars towards ultimate publication. We recommend the approval of this report as published and I so move. (This was seconded, there was no discussion the vote was taken and it was passed.)

THE CHAIR: It is a motion.

BIENNIAL LICENSING

3) (Dr. King continuing report) We had referred to us a portion of the Legislation and Public Relation Committee report dealing with the biennial relicensing of physicians. This was presented by Dr. Frank Owens yesterday. We recommend the approval, as read, and I so move. (Seconded by several)

THE CHAIR: Is there any discussion?

DR. HARVEY ATWELL, of Orangeburg: We met with the committee, yesterday, and tried to determine what the reason was behind this reregistration of physicians. We were unfortunate and unsuccessful, the Reference Committee had already completed their meeting but Dr. Wyman King and also Dr. Owens were kind enough to give us a hearing personally. Yesterday I and other members of my delegation sought at length to find the reason behind reregistration of physicians. We heard various reasons but we didn't hear one that we thought was sufficiently cogent to make this necessary. It seems one of the primary reasons that was given was that by reregistration every two years we can have means of policing our rolls. I feel, personally, that we could do a lot better of policing our rolls and determine those who are practicing properly or improperly in our community through our local medical Societies. I feel it is much simpler and it is certainly much less expensive and I believe much more practical to have the local secretary submit a list to the Board of Examiners each year listing those men who are practicing and are members of their local society in good standing and further listing those members who are not members of their Society but who are in good standing and should a question arise as to a man's ability to practice medicine the local Society could make a report to the Board of Medical Examiners. I should say there would be no reason for having reregistration every two years. I think from a personal standpoint,—we have not instructed our delegates from our society how to vote in this matter, but nevertheless I am opposed to it and I hope I will have



Photo by E. S. Powell

Pleasant Company

Gus Hart, Frank Owens, Billy Smith, Frank Cain

other like-minded people with me today. (Applause)
THE CHAIR: Is there any further discussion?

DR. GEORGE WILKINSON: (of Greenville) (Recognized by The Chair) The Board of Medical Examiners is not anxious to take on any more work than we have on us now. Last year we had ninety-four (94) papers to correct besides all of the rest of the duties that came to us. This matter of registration is not a local matter it is a matter that pertains to all of the states in the union and there are only six states in the union who don't have an annual or semi-annual registration. The number of doctors moving about from state to state—everytime you look up and see one of these mobile homes go by you see another part of a doctor moving somewhere else, too, and the matter of keeping up with them, the number of letters we have every year "Is so and so a licensed practitioner in South Carolina, if so, what is his address." There are many many inquiries coming in that would necessitate having some sort of a way of keeping up with doctors and this is no great big task. I don't care what kind of organization or association you belong to, even if you belong to CIO they have a list of members that belong and where they stay and who they work for; how much they are paid; and if they pay union dues. I don't belong to the CIO or the hod carriers' union either, however there are many reasons for keeping a log on doctors as well as on other people. You would be astounded at the number of inquiries we have and what we have to write and find out about people in some of the states where they do not have this type of registration. They come here and want to be licensed as doctors and sometimes it puts the Board in a very embarrassing position when we have very limited means of finding out about them. The matter of registration of physicians is not a matter of great import, I don't think it is going to make any dollar and cents difference to anybody here. I don't really believe it can be done for \$5.00 a head because after all is said and done with all the paying members we have the income would not be over \$5,000 to \$7,000 a year and to print a book with about 20 pages in it, with all these people's names in it and run them all down and keep them on current file, if you can do that for \$7,000 a year you are a damn sight better man than I am and I make pretty good money. (Laughter & Applause)

DR. GAINES (Recognized by The Chair): Mr. President, I venture to say if the Board of Medical Examiners want to know about a man you can call the County Medical Society and they can find out right quick, because the secretary of a medical society knows pretty well what is going on. I would hate to see another duty added to our own secretary, to our own selves and to our own pocketbooks. As far as I am personally concerned, and I am speaking only for myself, I would like to see this forgotten about. (Applause)

DR. WYMAN KING (Recognized): As chairman of this Committee I have one more word to say, I would like to cite this example that happened in our community a year or so ago. There was a graduate of the South Carolina medical school who was licensed some 35 years ago. He moved to one of the western states; was in practice for a while; was convicted in Court for the death of a person on whom he had committed an abortion; he served a good long sentence in this western state, his license in that state was revoked during the time he was in the penitentiary; when he was finally released from the penitentiary he came home; he went to a small town, had secured an office and was ready to begin practice when someone in the community became a little suspicious and enquired of the western state what his status was, and at that time they got the information concerning this individual. Had this not happened he would have set up his practice and no doubt would have done some of the things in South Carolina that he had been doing in the western states. Now, had we had such a law as is proposed here this thing could hardly have happened. I simply wanted to bring that point out.

DR. LABORDE (Recognized by The Chair:) I have heard that sort of thing quoted for justification of this thing. If that is the justification for this thing it could much more simply and with less difficulty to all of us be accomplished by simply passing a law that a person not practicing in this state for a period of say three years his license is automatically revoked. That wouldn't necessitate reregistering every one every two years. If you want to stop that particular aspect of it, it could much more simply be done.

DR. EVATT (Vice-President Presiding) Dr. Weston. DR. WM. WESTON, JR.: I am speaking in favor of the Reference Committee's report. I was looking for Dr. Harold Jervey, I don't think he is here, and he is secretary of the Board and I have talked with him about this several times. I see no reason for us to retrograde and I think we ought to go along with the other forty-four (44) states since there are only six (6) that do not have re-registration.

I hate to compare individuals or professions but I think we could learn something from the lawyers. When they go to court they spit at each other and fight each other and everything else and come out with their arms around each other. I think we might do the same thing. Now, my remarks in this connection is everything from the medical standpoint seems to be personal and I don't think we ought to have it that way and that is the trouble with not having re-registration. Just as Dr. Cain brought out, these people can come back here and practice medicine and if he is a good friend of yours, regardless of what damage or insult he has done to man, woman or child, you are going to help defend him. And we have had it in our own county and I think it is time that we had re-registration of doctors. (Applause.)

DR. EVATT: Is there any further discussion?

(Dr. Weston resumes the Chair.)

DR. ROBERT WILSON (Recognized by the Chair:) The minutes of the House of Delegates last year shows that this was adopted in principle by the house. It was referred to a reference committee, and that reference committee reported to the House. "The report

on biennial registration was reported by the biennial committee, the reference committee approved in principle the biennial committee for biennial registration of physicians licensed in the State of South Carolina, however we recommend the details of the general legislation be drawn up by the Committee on Legislation for presentation to the House next year and that the fee not exceed \$5.00." This recommendation of the Reference Committee was adopted last year.

(From the floor) Call for the question.

DR. HARVEY ATWILL (Recognized by The Chair:) Once again I have heard reasons why this should be done, one is that by doing it we would eliminate the example Dr. King mentioned of a man coming into a community to practice without having been there for several years and having been in difficulty in some other spot. I once again feel, and it has been brought out this morning, that the questionnaires would be very simple you would be asked your address, you would be asked your telephone number, if you limit your practice you would be asked that question. If we use a very simple form to get this information then we certainly would not be able to obtain the information that we would like to know about a man's character, in such a questionnaire. On the other hand the place I think it would be most apt to be found would be in his home society by local persons who know him and know him personally and not by a simple form to be sent out once every two years, filled in and returned to the Board of Medical Examiners. The second thing that has been given in argument this morning which I feel is very poor argument is that because 44 other states have taken this tack that we should take it. I have never been one to follow simply because someone else has done it. I feel if we are right and we have a valid reason perhaps they will change and come back to us. I am still very much opposed to this. (Applause)

THE CHAIR: Is there any further discussion?

DR. SAM FISHER (Greenville) (Recognized): I am in favor of this motion. I would like to report that I have my original license from the State of Pennsylvania and since 1943 have been sending in annual re-registration for this. I think that the annual re-registration is good but I think that it would be better if the State Board of Medical Examiners could keep closer track by having the re-registration officially countersigned by the Secretary of the County Society so that we could keep further track and make sure the members are in good standing.

THE CHAIR: Thank you Dr. Fisher. Is there any further discussion? It seems to me that in voting for this motion we are just confirming what we did last year.

All those in favor signify by rising. (The count was made by the tellers.) Now, those opposed to this confirmation, rise. (These were counted.)

I would ask the Sergeant-at-Arms to please give me a report.

DR. TIMMONS (Sergeant-at-Arms) Fifty (50) for; thirty (30) against.

THE CHAIR: The motion is passed, the motion passed last year is re-affirmed.

From the Floor: Doesn't it have to be a two-thirds vote to Pass? Is it an amendment to the by-laws, Mr. President?

THE CHAIR: I didn't think so, is it an amendment to the By-Laws? I don't think it is an amendment to the By-Laws.

MR. MEADORS: If it is not an amendment to the By-Laws it doesn't. Coming from Dr. King's committee on Amendments to the Constitution and By-Laws I thought it was.

THE CHAIR: We tried to even it up, Mr. Meadors and give some of them some of the reports that they didn't have to do, so that it would be equally dis-

tributed among the Reference Committees. Proceed, Dr. King.

DR. KING: Mr. President, I now move the adoption of the report as a whole. (This was seconded; there was no discussion; the vote was taken and it was passed.)

THE CHAIR: It is so ordered, it is a motion.

The next is the report of the Reference Committee on Insurance, Blue Cross and Blue Shield, Dr. Clay W. Evatt, Chairman.

(5) DR. EVATT: (Chairman Reference Committee on Insurance, Blue Cross, Blue Shield) The Reference Committee on Insurance, Blue Cross, Blue Shield considered the following reports and makes the following recommendations:

CARE OF INDIGENT

1) We move the adoption of Council's recommendation that care of the indigent be continued through present channels and that medical care not be added to the Social Security program, and that a letter to this effect be written by the Secretary of the S. C. Medical Association to each congressman and to the senators from South Carolina. I so move. (This was seconded, there was no discussion, the vote was taken and passed, and the Chair declared it was a motion.)

INSURANCE FORMS

2) We move the adoption of the resolution of the Edisto Medical Society concerning the standardization of insurance forms and that the President appoint a special committee to contact and work with a special committee from the insurance industry of South Carolina, (namely: Mr. George Hipp, Surety Insurance Company, Greenville, S. C., Mr. Charles Turner, Metropolitan Insurance Co., Charleston, S. C., and Mr. Frank Robeson, Life Insurance Company of Virginia, Charleston, S. C.) for the purpose of adopting standard forms such as those adopted by the Health Insurance Council. I so move. (This motion was seconded)

THE CHAIR: Is there any discussion? I thought, Dr. Evatt, you were on the committee that did discuss these problems with the committee.

DR. EVATT: There seems to be some overlapping, sir, in this deal, but Edisto brought this in and it was referred to our committee and we want this Association to appoint a committee to get in touch with the insurance people and together they agree on a standardization of forms.

(The question was called for from the floor; there was no further discussion; the vote was taken and it was passed; the Chair declared it a motion.)

CARE OF AGED

3) We move the adoption of Dr. Crawford's Committee Report on "Care of the Aging" as read, and I so move. (The same as Council's recommendation No. 4) (This was seconded, there was no discussion, the vote was taken and passed and the Chair declared it was a motion.)

AMEF

4) We move the adoption of Dr. Boyle's report and recommend that the A.M.E.F. be continued. I so move. (This motion was seconded, there was no discussion, the vote was taken and passed. The Chair declared it a motion.)

DR. EVATT: Mr. President, I move the adoption of the report as a whole. (This was seconded there was no discussion and the vote was taken and motion passed.)

THE CHAIR: It is so ordered.

INSURANCE

DR. EVATT: Now, I have a further report from the Insurance, Blue Cross and Blue Shield Committee.



Photo by E. S. Powell

Dr. Weston, Hon. James F. Byrnes, and
Dr. Vincent Askey.

This came in since we met yesterday, it is in an air mail letter from the Mutual Life Insurance Company with whom we have policies. I won't read the whole letter but anyway it states Mr. Ransom Williams continues as a broker of record in this state. (Reading) The company has no definite office at this time but a man will be sent to circulate the state entirely and take care of the needs. During the year 1959 the actual benefits in dollars paid to 28 of your members, \$9,704.00. During the first four months of 1960, 11 members were paid \$2,582.00 in benefits.

Since the inception of the group in August 1956 127 members have been paid a total of \$28,723.00. We are well pleased with the health of the plan from this aspect and trust your association and members are pleased with our benefits, pattern and service. In summary we are satisfied with the plan and hope your committee is too but extend the offer for you and any committee member to feel free to phone our home office at any time for any information that you may wish.

THE CHAIR: This report is received as information. I don't think any action need be taken on this.

We will now hear from the Reference Committee on Public and Industrial Health, Dr. R. L. Crawford, Chairman.

(6) DR. R. L. CRAWFORD, Chairman, Reference Committee on Public & Industrial Health.

This committee met in the T. V. Room, considered the four reports referred to it, and makes the following recommendations:

SCHOOL HEALTH

1) That the Report of the School Health Committee be approved and received as information. I so move. (This was seconded, there was no discussion, the vote was taken and it was passed and it was so ordered.)

CANCER

2) That the Report of the Cancer Committee be approved and received as information. I so move. (This motion was seconded, there was no discussion, the vote was taken, passed and it was so ordered.)

INDUSTRIAL FEES

3) That the Industrial Fee Schedule portion of the Report of the Chairman of Council be adopted. We also recommend that per case medical fee costs be obtained by the original fee schedule committee and compared with per case costs of other states, and that this comparison be presented to the State Chamber of Commerce at the opportune time. I so move, Mr. President. (This was seconded.)

THE CHAIR: Is there any discussion?

(Request from the floor that the recommendation be re-read.)

(Dr. Crawford re-reads) "That the Industrial Fee Schedule portion of the Report of the Chairman of Council be adopted. We also recommend that per case medical fee costs be obtained by the original fee schedule committee and compared with per case costs of other states, and that this comparison be presented to the State Chamber of Commerce at the opportune time."

THE CHAIR: Any discussion? (There was none, the vote was taken and the motion passed.) It is a motion. (Dr. Crawford continues report)

STATE BOARD OF HEALTH

4) That the Report of the Executive Committee of the State Board of Health to the State Medical Association be approved and adopted. We also recommend that the State Medical Association go on record as approving compulsory diphtheria, pertussis, tetanus and poliomyelitis vaccination of school children before they enter the first grade of school, and as favoring the passage of legislation toward that end." I so move, Mr. President. (This was seconded from the floor.)

THE CHAIR: Is there any discussion?

DR. PARKER: (Recognized) As regards polio vaccination, I would only like to raise the point that the technique of polio vaccination is in somewhat of a state of flux. You are all aware of the oral vaccines that are being developed and that are being tried on a socialistic basis in various places over the world and I would like to urge that any resolution that should be drawn up and approved would not specify that the vaccination be by use of a needle.

THE CHAIR: Thank you, doctor.

DR. CRAWFORD: Of course, we did not so specify in this resolution.

THE CHAIR: You recommend that we have compulsion, Dr. Crawford, in these vaccines?

COMPULSORY IMMUNIZATION

DR. CRAWFORD: We recommend that (reading) the State Medical Association go on record as approving compulsory diphtheria, pertussis, tetanus, and poliomyelitis vaccination of school children before they enter the 1st grade of school, and as favoring the passage of legislation toward that end.

THE CHAIR: Is there any further discussion? (The Chair requests Dr. Evatt to take the Chair.)

DR. EVATT (Takes the Chair and presides)

DR. WILLIAM WESTON, JR. (Recognized): Gentlemen, I want to discuss it. I think in compulsion we are doing, in this method, exactly what we are trying to fight against, that is socialized medicine. Now, I think we can get around this by passing one of them, say tetanus, with diphtheria and tetanus put together. As a matter of fact we put four altogether now and call it Quadrigen but I think we are doing a dangerous thing to say you have got to have these preventives in order to get in the schools; we are practicing one thing in trying to do away with socialized medicine and yet we are creating socialized medicine when we pass this measure. If you want to pass one of them I think you can pass tetanus or diphtheria and then give us a chance to combine them as we will do, but I just can't see a compulsory method in passing all of these. I think what we are going to attack is, of course, the low socio-economical scale because the other group, as our private patients, are being given that now and, as a pediatrician I just don't like to see compulsion. (Applause)

DR. WESTON resumes The Chair: Is there any further discussion?

DR. NORMAN O. EADDY, Sumter (Recognized): I think perhaps one major thing we are faced with here is whether or not we are going to combine what would be nice with what would be necessary. Tet-

anus is not an acute infectious disease so far as it involves other people, particularly, and diphtheria is. I would feel personally better satisfied and feel a little better if any such rule as this being proposed involved the protection of the individual against something which he might give to someone else rather than just to do something which would be nice to protect him against having himself. If I want to run the risk of sticking a nail in my foot and getting sick and dying, that is my business, but if I want to run the risk of having diphtheria and giving it to you, then it becomes your business as well as mine. It might be better if we could confine any such proposal to include protection against those things which might jeopardize other people rather than just the patient, himself. (Applause)

THE CHAIR: Any further discussion? If not, the motion shall be put. (The vote was taken by a standing, both for and against.) The motion is passed. (Applause)

Dr. Crawford (Continuing report)

"We also recommend that the Secretary of the State Medical Association be directed to write a letter of sympathy to the family of the late Dr. V. F. Platt, who served so faithfully as a member of the Executive Committee of the State Board of Health. (This was seconded, there was no discussion, the vote taken and the motion passed.)

We recommend the adoption of this reference committee report as a whole. (This motion was seconded, voted on and passed.)

THE CHAIR: The last Reference Committee is that of Miscellaneous Business, Dr. Charles May, Bennettsville, Chrm.

(7) Dr. Charles R. May, Chairman, Reference Committee on Miscellaneous Business. The Committee on Miscellaneous Business met in full membership. Dr. Harold Moody substituting for Dr. B. M. Montgomery. The following reports or portions of reports were considered and our recommendations follow:

WOMAN'S AUXILIARY

1) The report of the president of the Woman's Auxiliary, the committee recommends that this report be received as information and expresses its sincere gratitude and appreciation for the continued fine work of this organization. The Committee so moves. (This motion was seconded, there was no discussion; the vote was taken and it was passed.)

THE CHAIR: It is a motion.

BENEVOLENCE FUND

(DR. MAY) 2) The report of the Committee on Benevolence. This Committee recommends that the plan be adopted and put into effect. It further recommends that the plan be submitted in writing to each member of the association. It further recommends that \$20,000 be appropriated (or what portion of this amount Council deems advisable) as an initial allotment; it further recommends that the present committee be elected to serve as the original committee on the basis of the plans as set forth in the original proposal. This committee so moves.

THE CHAIR: Dr. Wilson informs me he doesn't think the House of Delegates can do anything about the financial end of it, that that is all up to Council.

DR. MAY: The recommendation was that \$20,000.00 be appropriated or what portion of this amount Council deems advisable.

THE CHAIR: Is there any further discussion?

DR. JOE CAIN (Recognized by The Chair): Gentlemen, I hope we don't get bogged down in discussion. I speak mainly to the \$20,000.00. I don't think Council would ever say that the House of Delegates couldn't tell them how much money they wanted to spend, whether it is in the Constitution or

not. I think the recommendation is perfectly in order. However, it gives Council plenty of leeway because it also says "whatever amount council deems advisable or finds necessary," so I move that we consider this favorably. I think it is very good, like it is.

THE CHAIR: Is there any further discussion? (There was none, the vote was taken and it was unanimously passed.) It is a motion.

"Suggested Plan for Operation of Benevolence Fund
"The Committee on Benevolence appointed by the president of the South Carolina Medical Association January 2, 1960, respectfully submits to council the following recommendations:

"(1) The South Carolina Medical Association shall establish a benevolence fund,

"(2) The purpose of this fund is to render pecuniary assistance to disabled or indigent physicians and to needy widows and children of deceased or disabled indigent physicians,

"(3) This fund shall be created by an initial allotment of \$10,000 (or so much as deemed wise by council); from established funds of the Association; from voluntary assessment of members; from contributions; and from such other sources as may be interested (Woman's Auxiliary, County Societies, Etc.).

"(4) The fund shall be administered by a "Board of Directors of the Benevolence Fund." This board shall consist of three members to be elected by the Association, one member for three years, one member for two years, one member for one year, term of office not to exceed three terms, and that vacancy may be filled by the chairman of council. The board shall elect its own chairman and secretary. The president, the treasurer, and the chairman of council shall be ex-officio members.

"(5) The directors shall be responsible for the administration of all monies entrusted to their care. It shall be their goal to establish a "Permanent Fund" from which only the interest may be used, it being understood that in the beginning this may not be at first possible.

"(6) The board of directors shall have power to make rules and regulations to enable it to determine who shall be entitled to assistance or relief, so that it will be able to carry out the purpose for which the benevolence fund is established. The directors shall have exclusive control in designating beneficiaries and shall determine the sum to appropriate for each. The names of the beneficiaries for reason of delicacy shall not be published and shall be known only to the directors and ex-officio officers.

"(7) The treasurer of the association shall be custodian of all benevolent funds and shall keep them entirely separate from all other Association accounts. He shall assist and advise with the directors on all matters concerning investments for the permanent fund and carry out their wishes in these matters. He shall pay out funds from this account only on certification of the directors.

"(8) The directors of the benevolence fund shall report to council prior to the annual meeting of the house of delegates and at such times during the year as may be deemed necessary by the chairman."

Committee

W. Atmar Smith, M. D.

O. B. Mayer, M. D.

Thomas G. Goldsmith, M. D.

Dr. Charles R. May (Continues Report)

CONVENTION CRUISE

3) The Committee report on the Convention Cruise. The committee approves the proposal to further investigate the idea of a cruise convention but with special attention to the legal qualifications of such a cruise and the advisability of separating the Business and Scientific portions of the convention. This Com-

mittee so moves. (This motion was seconded from the floor.)

THE CHAIR: Is there any discussion?

DR. PRIOLEAU (Recognized by The Chair): The scientific program Committee has had the difficulty of preparing a program, of inviting competent speakers and at the same time having little or no assurance that there will be a good attendance. The idea of the Cruise Convention really originated, I think, with Dr. Dale Groom. He has spent a lot of time and a lot of effort for the program. It was his idea, and came from other societies, that the cruise has met with a great deal of success so that we felt that that should be investigated further. Now, looking into it we see that there would be very great difficulties particularly in having a cruise convention for a state convention. There is so much business of a legal nature that we can readily imagine that you can not conduct that business out at sea because you would have all kinds of objections from various people that they were not able to be present to make their reports and to be frank. Now, furthermore, the cruise people say that if we are going to have a cruise, practically speaking, you have to come with your bag packed and get on the ship and they pull up the line. But, if you do not do that, if you come and have a meeting such as this and then go on the cruise, the cruise people say the delegates get telephone calls or give out of money and nobody gets on the boat. So the only real reason and the real way of doing it, and the scientific program committee has given this some consideration as to whether it would not be advisable to have two meetings of the association, one a short business meeting and then at another time a scientific program. The scientific program, I imagine, you could go anywhere. We think now that a great many people who have been here two or three days, they are not going to be able to remain, as well as they would like to, for the scientific program and we think some thought should be given to the idea of breaking the meeting down into two parts and thus obtain a better attendance of the scientific program.

THE CHAIR: Thank you, Dr. Prioleau. Is there any further discussion? (There was none, the vote was taken and the motion carried.)

(Dr. May's Committee Report continued)

CHILD WELFARE

4) The report on Child Welfare. This committee recommends that Dr. Hart's report be accepted as information and that Dr. Hart be complimented upon his active participation and leadership in the field of child welfare. This committee so moves. (This motion was seconded, there was no discussion, the vote was taken and the motion passed.)

5) Report on Allied Professions. No action taken on this report and no recommendation made by this committee. I so move. (This was seconded, the vote was taken and passed.)

6) Report of the Advisory Council to the Auxiliary. The committee wishes to commend Dr. R. L. Crawford for his helpful work with the auxiliary and recommends that the Council be continued. This committee so moves. (This was seconded, there was no discussion, the vote was taken and it was passed.)

7) Report on Rural Health. The Committee has no written report on this matter and no action is taken. (This was seconded, the vote was taken and passed.)

8) Report of Coroner and Medical Examiner. This report is received as information and recommends that the committee be maintained. The committee so moves. (This was seconded, there was no discussion, the vote was taken and passed.)

9) Report of the Medical Advisory Committee on Selective Service. The committee recommends that Dr. Owens' report be accepted as information and

that Dr. Owens be commended for his interested activity in this important matter. We so move. (This was seconded, there was no discussion and it was passed.)

ESSAY CONTEST

10) Report on Essay Contest. This Committee wishes to express grateful appreciation to Dr. Parker for his interest and work with this committee and to encourage Dr. Kilgore to continue this important work in Public Relations. We so move. (This motion was seconded, there was no discussion, the vote was taken and it was passed.)

DR. MAY: Doctor Weston, there was a point Dr. Wilson raised about the floor electing the committeemen for the benevolent association, do you want me to place those in nomination or do you want to wait to go to Council?

THE CHAIR: Well, I don't think it is necessary to go before Council unless somebody raises the question. I think it will come up at the election of officers.

DR. MAY: The Reference Committee on Miscellaneous Business recommends that this report be approved in whole. (This was seconded, there was no discussion, the vote was taken and it was passed.)

THE CHAIR: It is so ordered, the report is adopted as a whole. The Chair at this time would certainly wish to thank the chairmen of the various reference committees, and not only those men but the members of those committees on there with them, and the committees throughout the year that have been working and have done a good job and I have recommended to the Council that each committee be given a directive so that they will know what they are doing and there will not be any over-lapping.

I had one communication last week from the Secretary of the Lynchburg Medical Society and he wanted to know if we had any medical building or if any county owned their own medical building in regards to the telephone service, etc., set up, and I will be glad to turn this over to the incoming president or else Mr. Meadors can handle it. I have not answered it as yet.

There are a couple of messages (Reading)

"To the Officers, members of House of Delegates and other Members of the South Carolina Medical Association.

It is my wish that the meeting may be a success from every point of view.

I deeply regret that the condition of my health prevents me from attending. I will greatly miss the greetings of old friends which I have enjoyed in past years and in admiring their constant devotion to all that is best in our profession. I shall be thinking of you and watching the press for news of the meeting.

May every blessing descend upon you in the great work in which you have done so well.

With love and best wishes.

Signed William Weston, Sr."

This is addressed to me as president (Reading) telegram.

"Most sincere congratulations to you on completion of presidency of the South Carolina Medical Association. Very best wishes to Joseph P. Cain, Jr., MD on election and for a successful term. New Yorkers look forward to seeing you and working together on mutual interest. Norman S. Moore, MD, President Medical Society of the State of New York."

I think those are the messages. If there is no further business we will now go into the election of officers. The nomination for president-elect is now in order.

NOMINATIONS AND ELECTIONS

DR. J. DECHERD GUESS (Recognized by The Chair): It has long been an ambition of mine to place in nomination for the position of president-elect of this association the name of Dr. Charles N. Wyatt,

of Greenville. That ambition is now being realized. Some time ago our society and his society unanimously recommended that his name be presented and appointed a committee to work for his election. That committee, in turn, asked me to make this presentation to you. It would be interesting and perhaps it would be boring to many of you if I went into great detail in recounting Charles Wyatt's accomplishments but some things must be said. He is a South Carolinian, he was born in Easley, S. C., he attended Wofford College and he attended the College of Charleston, he graduated in 1927 from the Medical College of South Carolina. After two years of internship, one in Charleston and one in Greenville, he located in Laurens and for a short while practiced general medicine at that place, later in 1929 he moved to Greenville and he was associated with Dr. Hugh Smith in the practice of internal and diagnostic medicine. He remained with Dr. Smith until 1941 when he was ordered to active duty in the army as a captain, he stayed in the army five years and came out a full colonel and during that time he had a great opportunity to exercise his qualities of leadership and administrative ability. He was commanding officer of a station hospital in Okinawa, in Italy and in Iran. He came back in 1946 and opened his office in Greenville and has continued in the practice of general medicine from that time until this. He has had many honors bestowed upon him by his colleagues in medicine. He has been president of his county medical society in Greenville, he has been president of the South Carolina Chapter of the Academy of General Practice; for ten years he was the delegate from South Carolina to the National meeting of the Academy of General Practice, and for nine years he has been councilor of the Fourth Medical District. As councilor his work has been outstanding. I have never known a councilor to take his duties as seriously as he has taken them, sometimes he is so tenacious and so persevering in his duties as councilor that it becomes a burden upon those whom he asks to assist him in his work. A year ago Dr. Joe Cain, who had been Chairman of Council for so long, was elevated to the president-elect office, Charlie Wyatt was named vice-chairman of Council and his work this year has been outstanding, as I am sure you recognize from the report which he gave to us yesterday. Not only has he been interested in matters of medicine but he is a civic-minded individual. He is a member of the Lions Club for fourteen years and he has been president one term; he has been a member of the Chamber of Commerce of the City of Greenville for many years and he has been a member of the Chamber of Commerce of the United States. I wonder if any other doctor in South Carolina is a member of the Chamber of Commerce of the United States, I know of none. He has been a Shriner for many years and is medical director of his temple.

What is more important than the number of honors he has held is the way in which he has carried out the duties of those positions with which he has been honored and that work has been characterized by outstanding ability, intense interest, dedication to duty and qualities of leadership that are really remarkable. Therefore, Mr. President and members of the association it gives me a great deal of pleasure to place in nomination for the position of president-elect of this association Dr. Charles Newton Wyatt of Greenville. (Resounding applause.)

THE CHAIR: Dr. Wyatt has been nominated, is there a second?

DR. THOMAS R. GAINES of Anderson (Recognized by The Chair):

Some years ago when it became my good fortune and privilege to have an official connection with this state Association I was rather at a loss but it was my good fortune to have a man to come to me and call on me

and tell me he would be at my beck and call at any time. I want to say to you that the advice and counsel of Charlie Wyatt was of untold value to me. Coming from a neighboring county I have never had the opportunity to know him before this time. He not only knows medicine in a personal way but also organized medicine. He has worked on the county level, he has worked on the district level, he has worked on council, on the state level and on the national level and I want to say it gives me good pleasure, but I think I would say it is more of a privilege to second this nomination for president-elect of our Association. (Applause)

THE CHAIR: Thank you Dr. Gaines. Is there any further nomination?

DR. JOHNSON (Recognized) I move the nominations be closed.

THE CHAIR: Dr. Johnson moved that the nominations be closed (this was seconded) all in favor of this please signify by saying "aye". (It was unanimous.) All in favor of Dr. Wyatt as president-elect of the South Carolina Medical Association please stand (The convention rises and there is deafening applause)

I will ask Dr. Decherd Guess and Dr. Thomas Parker to seek out Dr. Wyatt and escort him to the rostrum. Dr. Goldsmith wouldn't you like to help.

(Vice-President) THE CHAIR: We are running a little bit late, so if you want to go on we will not wait until they find him. The nominations for vice-president are now in order.

DR. GEORGE D. JOHNSON, Spartanburg, (Recognized):

Members of the house of Delegates I wish to place in nomination for the office of Vice-President a member of the medical profession from Spartanburg County. Dr. Workman has worked hard and long in the practice of medicine. He had his own small private hospital there for many years, all of the cooking was done in his own kitchen; he has also been a civic leader, he was a prior president of the Rotary Club; he has been on the Board of Furman University for twenty years; he has been Chairman of the School Board for more years than he cares to remember and has also been on the County Board of Education. His lovely wife has been president of the South Carolina Woman's Medical Auxiliary and I think you would make no mistake in voting for Dr. B. J. Workman for Vice-President.

DR. WILKINSON (Recognized:) I would like to second the nomination of Dr. Workman for vice-president.

DR. CRAWFORD (Recognized) I would also like to second Dr. Workman's nomination.

Motion by Dr. Wyman King that the nominations be closed. (This was duly seconded, the vote was taken, it was unanimous) Thank you, that means that Dr. Workman is vice-president. (Applause)

(Dr. Charles N. Wyatt is escorted to the Rostrum amid applause with the convention standing.)

DR. CHARLES N. WYATT: Mr. President, gentlemen of the House of Delegates, you make me very humble but on the other hand very proud and I assure you that with your help I shall do my utmost to carry on the functions of this Association in the standard that has been set by my predecessors. Thank you very much. (Applause.)

THE CHAIR: Dr. Wyatt, we are very proud to have you as the president-elect and there is no doubt from what you have done in the past we are assured of your successful future. I would like to inform you that Dr. Workman is a close neighbor of yours has been elected as vice-president for the ensuing year.

(Secretary) THE CHAIR: The next in order is the office of Secretary.

DR. BACHMAN SMITH: (Recognized) Mr. Presi-



Photo by E. S. Powell

*The President elect, Charles N. Wyatt Speaking.
The perennial secretary, Robert Wilson in the background.*

dent, I would like to nominate Dr. Robert Wilson to succeed himself. (This was seconded by Dr. Sanders; motion made by Dr. Evatt that the nominations be closed; this was seconded, a vote was taken on closing the nominations and it was unanimously passed; the vote was taken on the election of Dr. Robert Wilson to succeed himself as Secretary of the South Carolina Medical Association and this was passed unanimously.)

THE CHAIR: Dr. Wilson is unanimously elected to succeed himself—with a vote of thanks. (Dr. Wilson rises and there is applause.)

(Treasurer) THE CHAIR: Treasurer—I think has been nominated by Council.

DR. WYATT (Chairman of Council, recognized) Mr. President, council would like to place in nomination Dr. Stokes for re-election.

THE CHAIR: Dr. Stokes is duly nominated through the council, as is called for by the Constitution and By-Laws.

DR. WILSON: Mr. Chairman, I move Dr. Stokes be elected by acclamation.

(This motion was seconded, the vote was taken and it was unanimous.)

THE CHAIR: Dr. Stokes is the Treasurer for the coming year.

Delegate to the A.M.A. (2-year term)

THE CHAIR: Delegate to the A.M.A., a two-year term, the term of Dr. George Dean Johnson expires December 31, 1960.

DR. WYMAN KING: (Recognized) Mr. President I would like the privilege of placing the name of Dr. George Dean Johnson to succeed himself. George has done an admirable job in taking care of us over the years and it gives me much pleasure to nominate him to succeed himself. (This was seconded)

THE CHAIR: Are there any further nominations?

(Several motions from the floor that the nominations be closed, these were seconded; the vote was taken and it was unanimous.) It is so ordered. All those in favor of Dr. George Dean Johnson to succeed himself as a delegate to the A.M.A. for the next two years please signify by saying "aye". (This was a unanimous vote) It is so ordered.

(Alternate Delegate to A.M.A.)—2-year term

THE CHAIR: The Alternate delegate to the A.M.A., a two-year term, the term of Dr. Charles N. Wyatt expires December 31, 1960. What is your pleasure, gentlemen?

DR. CAIN: I move that Dr. Chas N. Wyatt succeed himself as alternate delegate to the A.M.A. (This was seconded by Dr. Wilkinson; and motion was made that the nominations be closed, this was seconded,



Photo by E. S. Powell

Dr. B. J. Workman, Vice president.

voted on and passed. The vote was taken favoring Dr. Wyatt as the alternate delegate to the A.M.A. from the South Carolina Medical Association and it was unanimously passed)

THE CHAIR: Dr. Wyatt is the alternate delegate. (Councilors—3-year terms)

THE CHAIR: Councilors, three-year terms, the first district, the term of Dr. Bachman S. Smith, Jr., expires)

DR. J. ARTHUR SIEGLING (Recognized) I would like to nominate Dr. Bachman Smith to succeed himself.

THE CHAIR: Dr. Siegling nominates Dr. Bachman Smith to succeed himself, is there a second?

DR. THOMAS W. MESSERVY, Summerville, S. C. (Recognized) Mr. President I would like to place in nomination the name of Dr. Clay Evatt as councilor from the first district.

THE CHAIR: Dr. Clay Evatt has been nominated, and Dr. Evatt's name has been seconded. Please prepare your ballots. Is there any further nomination from this district? (There were none) I will ask Dr. Timmons and Dr. Sanders and their committees to pass out the ballots. (This is done)

THE CHAIR: Our newly elected vice-president, Dr. B. J. Workman has just come into the hall, I would be glad to have Dr. George Dean Johnson and Dr. George R. Wilkinson escort him to the rostrum. (Applause)

DR. B. J. WORKMAN (Spartanburg) Mr. President and fellow practitioners, I assure you I feel this is quite an honor to be an officer of this organization. I shall try to conduct myself at all times in the principles and practices of the ethics of this profession and I stand willing and ready at all times to assist the officers and members of this organization and give to this organization the best that I can. I thank you. (Applause.)

THE CHAIR: We thank you very much, Dr. Workman.

While the tellers are counting this, if you don't think it will confuse you any more than it will me, then we will proceed with the next district.

(Fourth District)—3 year term

Dr. Wyatt has just been elevated from Chairman of council to president-elect and his term expires, anyway, and he is not eligible, he being the president-elect, so we will have nominations from the Fourth District.

DR. GAINES (Recognized): In my neighboring county of Oconee, in the Town of Walhalla, we have one of our fellow practitioners whom we take great

pride in offering his name as councilor from the Fourth District, I refer to Dr. John P. Booker, better known as Jake Booker. He was born in a foreign state, he was born in North Carolina but early after getting his education at Charlotte and Duke University he came to the South Carolina medical school, where he graduated; he took his internship at the Greenville General Hospital. He located in Walhalla in 1938 and since that time, he has been practicing medicine there with the exception of four years which he served in the United States Army. He was Chief Surgeon of station hospitals and later commanding officer of the station hospital. He served in Africa, Italy and France. He came back to Walhalla and took an active part in the civic affairs of his town, he has been on the Board of Stewards of the Methodist Church for many years, he has served on Council; he has been Mayor pro tem, he has been president of the Rotary Club and in a practical way he has served well. He is known as a good citizen and a good doctor. He has been president of the county medical society, he has been Chief of Staff and Surgery at the Oconee County Hospital, and has had other honors, so you see we make no mistake though he has big shoes to fill in Charlie Wyatt's going. We feel that Jake Booker will make a good councilor and we take great pleasure in nominating him.

THE CHAIR: Thank you Dr. Gaines for the nomination. Dr. Goldsmith.

DR. GOLDSMITH: It gives me great pleasure and a great privilege to second the nomination of Dr. Booker as councilor from the fourth district.

THE CHAIR: Are there any further nominations? (motion was made by Dr. Wilkinson that the nominations be closed, this was seconded, there was no discussion the vote was taken and it was so ordered.) All those in favor of Dr. John P. Booker as councilor from the fourth district will please signify by saying "aye". (The vote was unanimous) Dr. John P. Booker is duly declared elected to serve as councilman from the Fourth District.

(Seventh District—3-year Term)

THE CHAIR: Next we have another district, the seventh district, the term of Dr. A. C. Bozard expires and if I am incorrect someone can correct me, I think Dr. Bozard has served three terms and is not eligible for re-election.

DR. EUGENE W. KELLER, from Clarendon, I would like to place in nomination the name of Dr. Norman Eaddy, from Sumter.

DR. C. R. F. BAKER, Sumter: (Recognized) I would like to second the nomination of Dr. Eaddy, he has been a hard worker for the medical Association for a number of years, he has been vice-president; he is very attentive to his duties, wherever he has been appointed, and I think he will make us a good man.

DR. NORMAN EADDY (Recognized:) It gives me particular pleasure to nominate for councilor from the 7th district Medical Society a very close friend of mine, a very successful and skilful surgeon known throughout the state for his accomplishments, particularly in the line of plastic surgery; a man of unusual mental abilities who would be quite an asset to our medical society in this particular position. I take pleasure in nominating and soliciting your votes for Dr. Murdoch R. Walker, of Sumter for the member of Council from the 7th District Medical Society.

THE CHAIR: Dr. Murdoch Walker has been nominated. Dr. Walker is standing in the back of the room and is coming forward.

DR. WALKER: May I speak, Mr. President?

THE CHAIR: You may.

DR. WALKER: I just want to say that I thank Norman Eaddy for his kind gesture in nominating me but for the good of the Society I would like to decline this nomination in favor of Dr. Eaddy. He has been

interested in the work, he has done a very good job as vice-president and as delegate for many years and I just feel that I would feel better if you allow me to decline the nomination, thank you.

THE CHAIR: Thank you, Dr. Walker. You have heard Dr. Walker's request, I think Dr. Eaddy should grant it. (laughter) Is there any further nomination? (Motion is made by Dr. Sanders that the nominations be closed, this was seconded, the vote was taken and the motion passed. The vote was taken on Dr. Norman Eaddy's nomination as Councilor from the 7th District, the vote was taken and the motion unanimously passed, with the exception of a "no" vote by Dr. Eaddy. Dr. Eaddy is duly declared the Seventh District representative and will succeed Dr. A. C. Bozard. I guess you will be put to work right away. (Returns from voting on 1st District Councilor)

THE CHAIR: On the election from the first district, Dr. Bachman Smith received 32 votes and Dr. Clay Evatt received 48. Dr. Evatt is declared the district representative from the First District.

(Members of Mediation Committee, 3-year terms.)

THE CHAIR: We will now vote on members of the Mediation Committee, 3-year terms. The term of Dr. John A. Siegling, First District, expires, do I hear a nomination?

DR. WYATT: Mr. President.

THE CHAIR: Dr. Wyatt.

DR. CHARLES N. WYATT, Chairman of Council: It is the custom of the Council to nominate two names from each district, where a member's term expires on the Mediation Committee.

THE CHAIR: I am glad you called this to my attention, I had forgotten it, we did it yesterday, I believe.

DR. WYATT: Shall I give them all at one time or just the First District.

THE CHAIR: I think you can give them all at one time and you can divide them on your ballots, if you will, there are three, the 1st District, the 4th District and the 7th District. If you will mark that on your ballot. There are two nominees from each district and then if you want to nominate from the floor, why then you can do that.

DR. WYATT: It is in the Constitution and By-Laws that these nominations shall come from Council, only, and they are not nominated from the floor.

THE CHAIR: That is right, gentlemen, these nominations are from council and are made by the councilor of each district concerned. Also, it is customary for the terms on the Mediation Committee to be only two, that is a man may serve six years and six years only.

DR. WYATT (Chairman of Council gives the following nominations for the Mediation Committee:

First District: Dr. H. C. Robertson, Charleston; Dr.

Warren S. Smith, Walterboro

Fourth District: Dr. Anthony White, Easley; Dr. Sam Moyle, Walhalla

Seventh District: Dr. S. E. Miller, Georgetown; Dr. T. M. Davis, Manning

THE CHAIR: Thank you, Dr. Wyatt. Gentlemen, the names are on the bulletin board. Prepare your ballots and the tellers will collect them.

If the tellers have collected the votes I will call on Dr. Charles R. May to give the nominations for the Benevolence Fund.

DR. CHARLES R. MAY (Recognized by the Chair) The Committee in session voted to re-elect the present members of this committee to serve as the first permanent committee and recommended further that they be appointed for one, two and three years in accordance with the way they were listed on the paper. That is the way they were selected, I therefore would like to put in nomination:

Dr. W. Atmar Smith for one (1) year term and Chairman

Dr. O. B. Mayer, for a two-year term.

Dr. Thomas G. Goldsmith for three years.

THE CHAIR: You have heard the nominations, what is your wish?

DR. J. H. GRESSETTE: (Recognized) I would like to move that the order of the nominations for the terms of office be reversed. Dr. Smith to be elected for a three (3) year term and down the line, as they were given to you. He had a great deal of work to do with this committee and also put a great deal of time into it and I think he, (Dr. Smith) should be the one to be elected for the longer period of time and I so move, and let "Chairman" go along with this.

DR. GOLDSMITH (Recognized) I should like to second that motion.

THE CHAIR: You have heard the motion, the motion is that Dr. William Atmar Smith be Chairman and serve for three years, Dr. Mayer serve for two years and Dr. Goldsmith serve for one year. Each of these men will be eligible for re-election. The motion has been made and duly seconded. Is there any discussion? (There was none, the vote was taken and it was passed.)

It is so ordered, Dr. Billy Smith, Chairman to serve 3-years.

Dr. O. B. Mayer, to serve 2-years.

Dr. Thomas Goldsmith, to serve 1-year.

Members of State Board of Medical Examiners—4-year terms)

THE CHAIR: If it is not working Dr. Timmons and Dr. Sanders Committee too diligently I would like to move on to the members of the State Board of Medical Examiners, 4-year terms. At Large, the term of Dr. Harold E. Jervey, Jr., expires. Dr. LaBorde (recognized).

DR. P. F. LABORDE, JR.: Mr. President, I would like to place in nomination the name of Dr. Hasell C. Ross, Columbia. (This was seconded.)

DR. GEORGE R. WILKINSON, Greenville, (Recognized): I would like to put in nomination the name of Dr. Harold Jervey. Dr. Jervey has been on the Board for some years now and this year the retiring president of the National Association of American Boards, in other words he has been district president of all the combined state boards in the United States and he has been able to exert some influence over the other boards in somewhat conformity with the ideas we had in South Carolina with regards that a person must be a citizen of the United States before he can practice medicine. He has got to be able to take up arms in case of war and he must have certain other qualifications, which we have always had in South Carolina and which many of the other states are gradually coming up to the standards that have been set in this state, and for those reasons and for the reason of the good work Dr. Jervey has done I would like to put his name in nomination.

DR. MAYER (Recognized) I second the nomination of Dr. Jervey.

DR. OWENS: (Recognized) I, too, would like to second the nomination of Dr. Jervey.

THE CHAIR: Dr. Evatt, if you would take The Chair I would like to say a word.

DR. CLAY EVATT (Presiding)

DR. WILLIAM WESTON, JR. (Recognized by The Chair): Mr. Chairman, the last three years Dr. Jervey and I have worked as co-chairmen of our local medical society and our duty is to get guests out-of-state guests, particularly, to our medical society and I certainly can commend him for the work he has done. As Dr. Wilkinson has told you he is the President of the State Board of Examiners, nationally, certainly he must be recognized as having some ability for getting



Photo by E. S. Powell

The gavel passes from Dr. Weston to Dr. Cain (left).

along with people, for doing things, and I take pleasure in seconding Dr. Jervev.

DR. EVATT: Any further nominations? Or speakers for seconds?

DR. WESTON (Resumes the Chair.) If there are no further nominations you will now prepare your ballot. Dr. Ross and Dr. Jervev, vote for one or the other.

(Results of the Mediation Committee Nominations) I will give you the results of the Mediation Committee Nominations, Dr. Henry Robertson, of Charleston is elected from the First District.

Dr. Anthony White, of Easley, is elected from the Fourth District.

Dr. S. E. Miller, of Georgetown, has been re-elected from the Seventh District.

Sixth Congressional District, the term of Dr. Harold S. Gilmore expires.

THE CHAIR: If the last votes have been collected, we will proceed, the term of Dr. Harold S. Gilmore, of the Sixth Congressional District expires. (Dr. Cain recognized)

DR. JOE CAIN, JR.: Mr. President, members of the House of Delegates, I would like to place the name of Dr. Gilmore in nomination to succeed himself. (This was seconded, and motion to close the nominations was made and seconded, this was voted on and passed.)

THE CHAIR: All in favor of Dr. Gilmore on the State Board of Medical Examiners please say "aye" (The vote was unanimous.) Dr. Gilmore is duly elected.

Members of the Hospital Advisory Council of State Board of Health—4-vr. Terms.

THE CHAIR: The term of Dr. Roderick Macdonald expires. Dr. John M. Brewer, Kershaw (Recognized): I would like to propose Dr. Roderick Macdonald to succeed himself. (This was seconded several times from the floor; motion was made and seconded that nominations be closed, was voted on and passed.)

THE CHAIR: All in favor of Dr. Roderick Macdonald to succeed himself as a member of the Hospital Advisory Council of the State Board of Health please signify by saying "aye". (The vote was unanimous) Dr. Roderick Macdonald is declared elected.

The term of Dr. B. J. Workman expires. Are there any nominations? (Dr. Wilkinson recognized)

DR. GEORGE R. WILKINSON: I nominate Dr. Workman to succeed himself. (This was seconded by Dr. Goldsmith, and motion was made seconded and passed that the nominations be closed. The vote was taken on the nomination for Dr. Workman to succeed himself and was unanimously passed.)

THE CHAIR: Dr. Workman is duly declared elected.

DR. O. B. MAYER (Recognized by The Chair): Are there any other vacancies on the Hospital Advisory Council? (There did not appear to be another vacancy.) (Dr. Wyatt and Dr. Cain answered in the negative.)

THE CHAIR: I wish to announce the results of the election for the members of the State Board of Medical Examiners, at large, Dr. Harold E. Jervev, Jr. has been elected to succeed himself.

(Announcement) DR. WYATT: For the benefit of the new Councilors I want to inform them that Council meets each morning that the State Medical Association is in session so we will have a meeting of council for reorganization at 8:30 in the morning in this room, Dr. Booker, Dr. Evatt and Dr. Eaddy will be present at that meeting.

THE CHAIR: Are there any further announcements? I would like to bring to your attention the excellent program which Dr. Prioleau, and Dr. Groom and Dr. Durst with ex-officio Dr. Wilson and I have arranged, but certainly we are indebted to Dr. Prioleau, Dr. Groom and Dr. Durst for an excellent scientific program, and I trust that the water will be too cold for you to go in and that you will stay in here. I certainly wish to thank the members of this committee for their excellent work in securing these outstanding doctors for our program.

THE 1961 ANNUAL MEETING

DR. RICHARD W. HANCKEL (Recognized by The Chair) Is the question in order to submit an invitation?

THE CHAIR: Yes, sir, we were waiting for such action.

DR. HANCKEL: I am Richard W. Hanckel from Charleston, S. C., and I have polled the members of our delegation and met no serious opposition to extending you an invitation to meet in Charleston next year. I also have in hand a telegram from the Francis Marion Hotel which states (reading) "Best wishes for a successful convention. The Francis Marion Hotel extends a cordial invitation to you and the members of the South Carolina Medical Association to hold your 1961 Convention with us."

I also have in hand information on the floor plan of the Francis Marion Hotel which I will be glad to turn over to the proper parties, and so—Charleston in 1961, if it is your pleasure.

THE CHAIR: Thank you very much Dr. Hanckel.

DR. JOHN M. BREWER (Recognized) Mr. President, I make a motion that we accept Charleston.

THE CHAIR: Dr. Brewer has made the motion that we accept Charleston's invitation. (Several seconds from the floor) It has been duly seconded by Dr. Wilkinson and by Dr. Milling. Under the discussion of this I would like to let the Greenville delegation know, in particular, that Mr. Mason Alexander is not asleep and he sent us a letter again inviting us to Greenville and so, if the Poinsette Hotel is not far removed by the time we meet next year, the Greenville delegation might consider this.

If there is no further discussion the motion will be put that we accept Dr. Hanckel's invitation to have our annual meeting in Charleston. All those in favor signify by saying "aye" (The motion was passed unanimously.) It is so ordered, we will meet in

Charleston with the Francis Marion Hotel as headquarters.

DR. THOMAS PARKER, Greenville: (Recognized by The Chair) Mr. President and delegates, this, I suppose is the end of our formal program but I would like to make a remark for the good of the order. We heard yesterday a statement that in all probability some Forand-type legislation would be enacted and I feel this is surely true. And, just as we are always given only two alternatives in the War with Russia, either atomic annihilation or surrender,—when we talk about Forand legislation we always say we are going to comply with it, and I believe in law, and I believe in rule by law but I would like to point out to the members that there is a third alternative to opposition or surrender and that is the alternative of nonparticipation.

The Federal Government can pass any legislation that

it sees fit to pass but the Federal Government is not able to practice medicine. Only doctors can practice medicine and nonparticipation means not that doctors will not treat patients but that they will not necessarily treat them the way that the Government demands they will be treated.

I will not hold you except to say that there is an organization which has given this matter long and careful thought and there is a table outside, somewhere, which is presided over by Dr. Roland Knight and there you will find considerable information on the subject of nonparticipation and other matters dealing with socialized medicine, and I call the table to your attention.

Dr. Robert Wilson (Recognized): I move the house of delegates give a rising vote of adjournment to Dr. Weston for a masterful parliamentarian's job. (Applause)

Adjournment *sine die*.

ANTIMICROBIAL CHEMOPROPHYLAXIS

Of the vast amount of antibiotics and other antimicrobial agents now being produced, a very large part is employed to prevent infection rather than for the treatment of actual infections. There are clear indications for such prophylaxis, but they are few. Most attempts at prophylaxis are likely to be ineffective; furthermore, they may lead to sensitization of the patient and toxic reactions; and in some cases instead of preventing infections, they cause superinfections.

Indications for prophylaxis—The prophylactic administration of penicillin or sulfonamides is of established value in preventing streptococcal infection and the recurrence of rheumatic fever in patients who have had previous attacks (*The Medical Letter*, May 15, 1959). Administration of penicillin or other antibacterial drugs to such patients prior to, during and after surgery and before and after dental extractions is also recommended for the prevention of bacterial endocarditis.

To help prevent rheumatic fever, bacterial endocarditis, and glomerulonephritis, whether or not there is a history of rheumatic fever, treatment with penicillin or other agents should be started promptly when any acute streptococcal infection, including scarlet fever, is discovered, and it should be continued for at least ten days (for preferred agents and dosages see the *Medical Letter* article cited above). Although L. Weinstein (*N. E. J. of Med.*, 253:679, 1955) found that the incidence of bacterial infections following measles was significantly greater in patients who had been treated prophylactically than in untreated patients, *Medical Letter* consultants believe that the doses used may have been inadequate and that antibacterial prophylaxis may be useful in preventing bacterial complications of measles. There is no disagreement, however, with Dr. Weinstein's statement (*Ann. Int. Med.*, 43:287, 1955) that the prophylactic use of antimicrobial agents in mumps, chicken-pox, varicella, infectious mononucleosis and pertussis has no beneficial effects, and that such prophylaxis in

respiratory poliomyelitis increases the risk of pneumonia and other bacterial infections.

Other indications—Penicillin provides effective protection against gonorrhea when it is administered after exposure. Eye instillation of penicillin also protects the newborn against gonorrheal ophthalmia. Sulfonamides are of definite value in protecting persons exposed to bacillary dysentery and meningococcal infection. A number of reports attest to the prophylactic value of pre-operative oral administration of such non-absorbed agents as neomycin, streptomycin and certain sulfonamides in the preparation of patients for gastrointestinal surgery.

There are no other clear-cut indications for antibiotic prophylaxis; on the contrary, a number of carefully controlled studies indicate that efforts at prophylaxis may be harmful. Antimicrobial agents are often used in an attempt to prevent bacterial infection following colds and other viral infections of the upper respiratory tract. There is no well-documented proof that bacterial complications of upper respiratory infections are diminished by such attempts at prophylaxis.

Patients with acute heart failure are particularly susceptible to the development of pneumonia. R. G. Petersdorf and R. K. Merchant (*N. E. J. of Med.*, 260:565, 1959) report that prophylactic use of antibiotics in such patients was ineffective in preventing this complication. Their findings do not support the view that antibiotics should be given routinely to patients with congestive heart failure.

Surgery—Antibiotics are often administered before or after surgery to control postoperative infections. Three carefully controlled studies indicate the undesirability of this procedure. M. D. Tachdjian and E. L. Compere (*J. Internat. Coll. Surg.*, 28:797, 1957) report that in 3,000 "clean" major orthopedic operations, 5.9% of 1900 patients given antibiotics prophylactically became infected, as compared with 2.6% of 1100 untreated patients. R. Sanchez-Ubeda, et al. (*N. E. J. of Med.*, 259:1045, 1958) studied 511 surgical cases and concluded that the prevalence of infectious complications is not affected by the routine administration of penicillin and streptomycin pre-

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operatively. R. S. Myers (*Surg. Gyn. & Obst.*, 108: 721, 1959) found that in 1536 consecutive cases, postoperative infections following herniorrhaphy were three times as frequent in patients receiving prophylactic treatment as in patients not receiving such treatment. Dr. Myers also noted that penicillin, streptomycin and tetracycline were most often used for such prophylaxis despite the fact that a very high proportion of hospital staphylococcal strains are resistant to these antibiotics.

Antibiotic prophylaxis is often used by obstetricians following labor in the hope of preventing post-partum infection. Where the patient has a prolonged and difficult labor, such administration may possibly serve a useful purpose, but present evidence does not justify the routine use of antibiotic prophylaxis following delivery. Urinary infection following catheterization is an all too frequent occurrence even with rigid

aseptic techniques, especially in the presence of an indwelling catheter. A high incidence of such infections occurs despite the prophylactic use of sulfonamides and other antimicrobials. The best way to minimize this possibility is to avoid catheterization, especially of the indwelling type, whenever possible.

The many authorities consulted by *The Medical Letter* were in full agreement in opposing the prophylactic use of antimicrobial agents except in the few conditions in which such prophylaxis is clearly indicated. Possible injury to the patient from sensitization, toxic reactions or superinfection is only part of the problem. The financial burden resulting from the needless use of expensive drugs can also be serious. Furthermore, the whole community suffers when increased bacterial resistance to antibiotic results from their wasteful use.

The Medical Letter

BOOK REVIEW

SURGERY IN WORLD WAR II; NEUROSURGERY VOL. II. Prepared and published under direction of Major General S. B. Hays, the Surgeon General, United States Army. Government Printing Office, Washington, D. C., 1959. Price: \$7.00.

This is the second volume of the history of neurosurgery in World War II. The first volume published in 1958 dealt with the management of head injuries and their residua. This second and final volume in the neurosurgical series deals with injuries and diseases of the spine and peripheral nerve injuries. This book is written by many eminent doctors, most of whom served in the United States Army during World War II.

The first half of the book is devoted to injuries of the spinal cord and covers in considerable detail the emergency care of these injuries, the urological aspects, the rehabilitation of paraplegic patients, and

the management of ruptured intervertebral discs. The chapter on the management of the urologic aspects of spinal cord injuries is particularly good.

The portion of the book devoted to peripheral nerve injuries contains an excellent chapter on standard methods of examination in peripheral nerve injuries as well as excellent chapters on the anatomic approaches and surgical technique of peripheral nerve repair. Other aspects of peripheral nerve injury, such as vascular injury, causalgia, and physical therapy in the management are considered in detail. A chapter is also devoted to orthopaedic techniques for use in irreparable nerve injuries.

In addition to its historical significance of the record of neurosurgery in World War II, this book is of considerable interest to both the student and practitioner of neurosurgery. Most of the chapters are clearly written and the illustrations are excellent. I would recommend this book for anyone having to do with the care of the paraplegic patient or peripheral nerve injuries.

Luther C. Martin, M. D.

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THE PHYSICIAN AND THE ALCOHOLIC

WALTER R. MEAD, M. D.
Florence, S. C.

The medical profession has always been reluctant to grapple with the problems which are inherent in alcoholism. Physicians have long given lip service to the idea that alcoholism is a disease and that the alcoholic is a sick person, but the vast majority of the profession lacks any enthusiasm for engaging in work with alcoholics, either in treatment of the individual victim or in the broader attack on the public health problem which alcoholism has now become.

The reasons for such reluctance are not hard to find. In general those reasons fall into two categories — first, the instinctive attitude of the doctor toward the alcoholic and his problems and second, the state of mind engendered by disappointing results in the treatment of alcoholics.

Physicians generally reflect the thinking and attitudes of the society in which they operate, and a very large segment of society looks on the alcoholic as an object of contempt and ridicule. Most of us enjoy our moderate use of alcohol as a social lubricant. Our restraint in its use gives us a sense of superiority over the individual who cannot control his drinking. By comparison he is a weakling, lacking in both judgement and self control. Instinctively we class him with the other socially unacceptable and medically uninteresting patients. It is probably not surprising that physicians should lag behind the clergy in their wholehearted acceptance of the Christian doctrine of the brotherhood of man. "There, but for the grace of God, go I" becomes instead — "What a pity — and he had such tremendous

The medical problems inherent in chronic alcoholism have long failed to provoke enthusiastic response from physicians. This is due in part to instinctive attitudes of doctors and in part to disappointing past experiences with alcoholics. The conception of chronic alcoholism as a disease has been accepted reluctantly, sometimes with tongue in cheek. The role of alcohol as an anesthetic is emphasized. Newer methods of treatment provide a much more effective approach to some of the more troublesome aspects of this great and growing public health problem.

possibilities". Nor is it fair to stigmatize the medical profession alone for their failure to apply this fundamental Christian principle in relationship to the alcoholic — a great many clergymen have adopted the same attitude.

Then, too, it must be remembered that physicians are individualists. They are at their best as solo performers, not as members of a team. And teamwork is the keynote in working with alcoholics. Clergymen, counsellors and laymen in Alcoholics Anonymous with their varied skills and differing approaches are all essential to any long range program of rehabilitation of the alcoholic. A physician accustomed to having his opinions respected and advice followed implicitly by his patients is due for a rude awakening when he expects such response from his alcoholic patient. The addictive drinker will listen to and agree with the dire predictions his physician presents but his subsequent behavior leads inevitably to the conclusion that he heard not a word that

was said to him, or hearing it, reacted in the manner so characteristic of the alcoholic — "It can't happen to me".

Perhaps there is in most of us a bit of the sadist. That regrettable trait comes to the front when we encounter an alcoholic who fails to take our considered advice and continues to drink even after we have pointed out to him that alcohol is responsible for his difficulties with his work, with his family, and with his health. It is difficult, in such circumstances, to refrain from the caustic comments which such conduct would seem to justify. But there are several reasons why the physician should curb his impulse to administer a tongue-lashing. In the first place his own composure takes a severe beating; secondly, he seriously jeopardizes his chances of ever retaining the confidence of the alcoholic who has already been kicked around to the limit of endurance; and finally, the patient, confused as he is by what the A. A.s call "alcoholic thinking", is in no way able to accept correction and reacts with resentment. This failure of the alcoholic to heed advice based on perfectly obvious reasons is not due so much to his innate contrariness as to actual impairment of frontal lobe brain function, recognizable as Bennett¹ has shown, by significant changes from the normal in the electroencephalogram patterns.

Bitter experience has taught most doctors that the alcoholic can rarely be handled successfully at home. The patience of his long suffering family has been so thoroughly exhausted that they either submit to his judgement about needing another drink or badger him into more extravagant displays of abnormal behavior to attain his objective of oblivion. What is the doctor to do then when he knows he is licked before he starts if he has to use home treatment? Too many hospitals have imposed such restrictions about admission of alcoholics that they can only enter by subterfuge or at prohibitive expense. The commercial drying-out establishments offer no solution other than a temporary and expensive surcease from the annoyance of the alcoholic's unpredictable behavior. It is not remarkable that, in such circumstances, most doctors pre-

fer to steer clear of any commitment in the treatment of the alcoholic.

The recognition of alcoholism as a disease would seem to place it in such a distinctive category that the full and complete cooperation of the medical profession would be enlisted unquestioningly. But such is not the case. In the first place there are many who challenge the statement that it is a disease — they say this terminology is being used so that the constructive attitude which is entertained toward the sick can be extended to cover a difficult social problem. Then there is the matter of professional pride — physicians, not laymen, have traditionally laid the ground rules for any new disease. In the case of alcoholism the moving spirits have been laymen rather than physicians.

As far back as 1804, Thomas Trotter, an Edinburgh physician, had proclaimed in a widely read essay, that chronic drunkenness was a disease. But the clergy of that day regarded him as a poacher on their private preserves. Salvation of the village tosspot was the privilege of the men of the cloth who, if they failed to reform him, could always use him as a whipping boy. To explain chronic drunkenness on a physical basis rather than as a manifestation of the depravity of man was, in those days, closely akin to heresy. While such ideas are not as universally held now, they still color the thinking of many zealots in the fight against the use of beverage alcohol.

Throughout the 19th century in this country there were occasional abortive efforts to establish some institutions where alcoholism could be treated but no real progress toward accepting the alcoholic into the ranks of the simply sick was made until after the first World War. The impetus for this somewhat revolutionary idea came largely from two sources, the Laboratory for Applied Physiology in connection with Yale University and the enthusiastic membership of a new and vital organization known as Alcoholics Anonymous. Both of these began to sway public opinion in the early '30's and in 1946 the 158th General Assembly of the Presbyterian Church in the United States formally recognized the proposition that after drinking had passed a certain point, alcoholism is a disease and that

thereafter drinking cannot be controlled by mere resolution on the part of the drinker.

This was a big break-through, but however learned this august body of the Presbyterian Church might be, its concept of what constitutes the earmarks of a disease would hardly satisfy the more exacting criteria of the medical profession. Somewhat belatedly and with considerable nudging from non-medical groups organized medicine has come to take its stand unreservedly with the proponents of the disease theory. But every physician is not thereby compelled to subscribe to it and many will continue to have doubts about the true classification of this vast problem with its manifold etiological factors, protean symptomatology and confusion of techniques for treatment. Even the doubters, however, will have to admit that only since the disease conception of alcoholism has taken root has there been any real advance in its therapy.

Alcohol, like ether, is primarily an anesthetic. Its administration, as in the case of ether, is attended by an initial period of excitement, later followed by a period of varying degrees of anesthesia. Then, as the agent is withdrawn, the excitation reappears. Alcoholic euphoria, somnolence, stupor and hangover have their counterparts in the stages of ether anesthesia. Ether is used to prevent and relieve physical pain; the anesthetic properties of alcohol are employed chiefly for the relief of mental pain.

Mental pain takes many forms — frustrations, intolerance for anxiety or tension, feelings of isolation, suspicion, feelings of inferiority, fears of all sorts, disappointments. A low threshold for mental pain is a personality characteristic of the majority of persons who become addicted to alcohol. And for them alcohol works. It may destroy his career, his marriage, his health — but for relief of his immediate mental pain nothing works as quickly or as consistently. And no anesthetic or tranquilizer has a more disturbing aftermath. There is no evidence that alcoholism can develop in the absence of some mental or emotional disability. When that disability vanishes, temporarily to be sure, under the effects of alcohol, the stage is set for the initiation of another victim into the burgeon-

ing ranks of the addictive drinkers. There are already over five million of them in this country.

Treatment of the chronic alcoholic is undergoing constant change. Many approaches have been advocated. Each has had some brilliant results but in all candor it must be admitted that the failures far outnumber the successes. To make treatment in some form available to the alcoholic is still one of the major challenges to the medical profession. That it has not been met as wholeheartedly as other public health problems is understandable but with more and more hospitals accepting alcoholics as patients and with ever more effective means of controlling the acute phases of this chronic illness, definite headway is being made. The introduction of such tranquilizers as promazine, chlorpromazine and trifluoperazine has given physicians much more effective aids for the drying-out period. The possible benefits of hypnosis in creating aversion to alcohol are beginning to be reported.² Disulfiram (Antabuse) has already proved itself an effective deterrent, especially where the assistance of a third party, the employer or the spouse, can be enlisted to ensure the uninterrupted administration of the drug.

To regard the completion of the drying-out period as the end of the physician's responsibility to his alcoholic patient is to miss a singular opportunity for starting him on the road to arresting his otherwise progressive disease. A cursory warning to avoid liquor in the future is about as effective as telling the diabetic to cut out sugar. Such cavalier dismissal might be excusable with the skid-row alcoholic but it must be remembered that these constitute about 5% of the problem drinkers. The phenomenally effective efforts of A. A. are available in almost every community for follow-up and many state sponsored programs for long term rehabilitation are in operation or planned for the near future.

No worker in the field of alcoholism has any illusions about the success of the present approaches to this great public health problem. Indeed, many have concluded that the eventual control of alcoholism will be found in the realm of prevention rather than treatment. Here we have two choices — a

quicken public comprehension of the causes, symptoms and essential nature of the disease or the abolition of alcohol. With respect to this last terrifying possibility Berton Roueche³ in a recent issue of *The New Yorker* quotes St. John Chrysostom in whose *Homilies* written in the 4th century appeared this pertinent observation — "I hear many cry, 'Would there were no wine! O folly! O madness!' Is it the wine that causes the abuse? No. (For) if you say, 'Would there were no wine!' because of drunkards, then you must say, going on by degrees, 'Would there were no night!' because of the thieves, 'Would there were no light' because of the informers, and 'Would there were no women' because of adultery."

In more recent times this same thought has been up-dated in the argument that we should prohibit the sale of sugar because our diabetic population would be harmed by its excessive use.

By whatever means alcoholism is finally controlled, if ever, there are with us, as of today, over five million alcoholics. Their medical problems are very real — they cannot be shrugged off nor side-stepped.

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ACCIDENTS IN CHILDREN

JULIAN P. PRICE, M. D.

Florence, S. C.

The leading cause of death in children in this country is accidents. In 1957, the last year for which figures are available, there were approximately fifteen thousand boys and girls under the age of 15 who lost their lives through accidents. In South Carolina there were 348 deaths from accidents in children, with the causes as follows:

Automobiles	100
Fire and burns	73
Mechanical suffocation	52
Drowning	38
Food obstruction or suffocation	35
Poisoning	7
Falls	6
Firearms	4
Miscellaneous	33

Comparison of vital statistics on the national level with those of South Carolina shows that the fatal accident rate (number of deaths per 100,000 of population) in South Carolina was well above the national average. In this state we had a proportionately larger number of deaths due to motor vehicles, fire, firearms, and drowning. We were below the national average in fatalities due to railroads, aircraft, and falls.

Accidents are the greatest enemy of the life and welfare of our children. The practicing physician must be in the vanguard of those who deal with accidents — their care and their prevention. He must not only know how to handle the severely injured child, but he must participate actively in an educational campaign to prevent accidents. This campaign should be carried on in his office, in the home, and at any public gathering at which he has the opportunity to speak.

The figures which I have cited have reference to fatalities only. For every child killed, there were probably four or five permanently disabled or crippled. This means that some 75,000 children in the U. S. and 1,700 in S. C. suffer fatal or serious injuries each year. Add to this the thousands upon thousands of youngsters who suffer lesser injuries with temporary disability and need for medical care, and one begins to sense the magnitude of the condition which exists.

The problem which I have presented is of national concern and can be solved only as all of those who are involved—the children and all of those who deal with children—coordinate their efforts in a united campaign to

reduce the tragic toll. And if the physician is to fulfill his role as protector of the health of the people, he must be in the forefront of this united band.

What can you and I as practicing physicians do in a crusade against accidents? The first essential is that we acknowledge facts. The nature of our daily work tends to make us think of death and medical need in terms of disease, and it is difficult for us to realize that accidents are the leading killer andcrippler of our children. We must realize that automobiles, fire, drownings, and firearms are greater menaces to the lives and health of our boys and girls than poliomyelitis, diphtheria, tuberculosis, and rheumatic fever. We must convince ourselves that most accidents can be prevented and that it is our duty to advise and educate toward this end.

It is also essential that we recognize those various human factors which enter into the creation of accidents and learn how to deal with them—the inability of an infant to care for itself, the innate curiosity and adventuresomeness of children, the assertiveness and desire to show off of the adolescent, the failure of parents to accept the responsibility which is theirs, ordinary carelessness as well as indifference and ignorance in both adults and children.

In any educational program aimed toward reducing the number and hazards of accidents, the physician should begin with himself. Through panels such as is being held today and through study, he must keep aware of the best methods of treating the injured child. He must know how to determine which patient can be treated in the office and which needs to go to the hospital; how to care for the patient in shock; how to handle the child with extensive burns or with a severe head injury. Above all, he should know how far he can go with his own abilities and training and when he should call on colleagues for help.

One particular phase of the program in which the physician will need help is in the realm of poisons. Drugs, insecticides, rat poison, floor polish—is there anything the youngster will not sample? (It has been estimated that 600,000 youngsters in this country swallow poison each year.) Fortunately we

now have Poisons Centers in Columbia and Charleston, and all a physician needs to do, day or night, is to call one of these and the information he needs is forthcoming.

The physician would do well to adopt a safety program in his use of drugs. Careful instructions should be given to the druggist and to the family when drugs are prescribed. The father or mother should be told what the drug is for and how it is to be given. General instruction on the label should be avoided. "A teaspoonful as needed" may be understood the day the drug is prescribed, but a month later the parents may have forgotten the indication for its use and the size of the spoon to be used—with unfortunate results.

The amount of drug prescribed should be limited to a quantity sufficient for two or three days. To prescribe only what is needed for an acute illness and that only for a specific period of time is good medicine—and it is also one of the first steps in the prevention of drug poisoning. The medicine closets of many families are cluttered with bottles half filled with medicine and boxes partially filled with tablets which are potential poisoners of children.

In talking to parents in his office, the physician should keep accidents ever in mind and should discuss their prevention. This is of particular importance when there are younger children in the family. Mention should be made of the type of activities in which the child is likely to participate and the need for special care that should be taken with respect to stoves, floor furnaces, electric outlets, electric cords, insecticides, stepladders, etc. If possible, the parent should be given a check list of potential danger points in the home and yard which he can use as a reference. Parents should be urged to teach safety practices to their children—when and where to ride tricycles and bicycles, how to cross a street, how to walk along the public highway, how and where to shoot air rifles, under what circumstances to swim and dive, etc.

The children themselves should be talked to about accidents. Many a youngster will pay more attention to his doctor than he will to his parents, and this is particularly true of the older child and adolescent.

While paying calls in the home, the physi-

cian should cast an appraising eye on the house and yard. Are the stairs safe? Are matches and cigarette lighters lying around? Are there safeguards around the stove or floor furnace? Are the screens in the windows well anchored? Are there open ditches in the yard? These are but a few of the questions which the observing physician might ask himself as he goes on his way.

Literature relative to accidents and their prevention should be available in the physician's office, and parents should be urged to take this material home for careful reading. Pamphlets on safety are available from several insurance companies, from some health departments, and from certain medical organizations, and these should be used freely. There is no telling how much effect such reading has, since statistics give the number of accidents sustained and not the number prevented, but I am sure that much good does ensue.

Finally, the physician must become a crusader in the cause of accident prevention. In season and out, he must preach the gospel of safety. In the office, in the home, at meetings of the P. T. A., before service clubs and church groups, in public gatherings of various types, he must discuss the problem and enlist the support of others.

Poliomyelitis did not disappear with the announcement of the Salk vaccine. It will be eradicated only when the public is educated as to the value of the product and takes the necessary steps to have everyone vaccinated. Just so accidents will not be brought under

control through studies of their incidence and cause. They will be reduced in number only as all of us who deal with children, along with the children themselves, appreciate and understand the problem and put into effect the various measures which are needed to protect our boys and girls against the great killer andcrippler of childhood.

Pamphlets are available to physicians for distribution to their patients.

The companies which publish them are glad to send them to physicians free—in quantities up to 100 to 200—upon request.

Metropolitan Life Insurance Company
One Madison Ave., New York

A Formula for Child Safety

Caution—Babies learning

Your Family's Safety

Health Education Service

John Hancock Mutual Life Insurance Co.

200 Berkley St., Boston

When the Unexpected Happens

Safe at Home—and in the Community

Prudential Life Insurance Company of

America, Newark, N. J.

Check Your Home

Safety—Your Children's Heritage

A large number of pamphlets dealing with various types and phases of accidents is published by

National Safety Council

425 N. Michigan Ave., Chicago

A list can be had upon request. They are sold at a minimum cost.

ENDOMETRIOSIS

SOME UNUSUAL FEATURES

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The purpose of this paper is to present some of the more unusual situations in which endometriosis may occur, and to discuss the treatment of endometriosis in general. The discussion is along clinical lines and will be confined to external endometriosis. This is defined as ectopic endometrium occurring elsewhere than in the uterine musculature, as contrasted with internal endometriosis or adenomyosis.

We think of endometriosis as being a disease of menstrual life occurring most frequently between the ages of 30 and 40 years, with a history of sterility. Acquired dysmenorrhea, or aggravation of already existing dysmenorrhea is present, as well as pre-menstrual and post-menstrual pain. Often there is dyspareunia and there may be painful defecation if the rectum is involved. The process progresses slowly and steadily until the pain is severe and constant. There may be menstrual irregularity, with the passage of dark blood.

The finding of enlarged ovaries is a well-known sign, as well as fixed, tender, nodular masses in the cul-de-sac, or the posterior surface of the uterus and along the utero-sacral ligaments. Such is the usual pattern of the disease. However, deviations from this occur sufficiently frequently to require consideration. Some of these are as follows:

1. *Early Endometriosis*—Endometriosis may occur fairly frequently in the 20-30 year age group, when the clinical course is more rapid and severe. It should not be excluded on age alone. Fallon³ reports nine cases under the age of 20; Clark¹ reports the youngest in a girl 11 years of age.
2. *Post-Menopausal Endometriosis*—At the other extreme we may encounter endometriosis after the menopause. The process is generally considered to be dependent on ovarian function, however it has been reported frequently enough in post-menopausal women that it should be definitely

There may be a relative as well as absolute increase in the incidence of pelvic endometriosis. If this disease is kept in mind it may explain some of the vague symptoms which are sometimes encountered. Endometriosis has many variations, and may occur at an early age or after the menopause, in the fertile multipara as well as the infertile nulligravida. There may be few physical findings with severe symptoms, or pronounced findings with mild symptoms. Medical treatment is successful more often than is realized. Spontaneous regression is always a possibility. Treatment may vary all the way from mild analgesics to radical surgery, including radiation therapy.

considered when the signs and symptoms are present. Hunt¹ reports a case 9 years after the menopause in a 59 year old woman who had cramping pain in the lower abdomen for 2 years. At operation a chocolate cyst was removed from the cul-de-sac.

3. *Endometriosis Associated with Normal Fertility*—Endometriosis has occurred in many instances after several normal pregnancies.¹ TeLinde⁷ reports about 33% absolute and 46% relative sterility in endometriosis. The incidence of sterility, however is greater than the incidence of closed tubes, so that other factors are at work in the prevention of conception, that is, other than the failure of ovulation. In the absence of ovulation there is less pain, and there may be a standstill or regression of the process.
- 3a. *Fertility may be present while endometriosis is progressing.* Conservative treatment of endometriosis is frequently followed by several pregnancies even though the process may be progressing during this period of fertility. This becomes evident later when the symptoms and findings are again severe enough to require a second operation and the advanced process is found. This occurs frequently enough to

justify conservative surgical treatment when surgery is indicated.

4. *Asymptomatic Endometriosis*—Another deviation is extensive endometriosis without symptoms. It is not unusual to discover the typical findings of endometriosis in the absence of any symptoms whatsoever—no pain, no infertility, and no menstrual irregularity. Also, it is not unusual to operate for ovarian enlargement, or for what appears to be inflammatory disease and find endometrial implants scattered over the pelvic peritoneum, or an endometrial cyst of the ovary. Operation is justified in the presence of sufficient findings and especially in the presence of persistent ovarian enlargement. This latter remark is based on TeLinde's⁸ figure of 15% malignancy in ovarian neoplasms. On the other hand, when there is pain only, and no palpable findings, one should be more hesitant to operate unless the symptoms are properly evaluated, and the pain is definitely incapacitating. It is in such doubtful cases that culdoscopy may be of value.

- 4a. *Dormant Endometriosis* — Related to the asymptomatic disease is dormant endometriosis. In the former there were findings but no symptoms. Here we have symptoms with minimal or no findings. Many cases will occur with mild but characteristic symptoms in the absence of the usual pelvic findings. The cul-de-sac may be slightly tender and show some thickening, but the symptoms are easily controlled by mild analgesics for a number of years. While a tentative diagnosis of endometriosis may be made, the symptoms and findings are not sufficient to warrant operation until after 10 or 15 years. This type of clinical course may explain some of the more obscure and vague symptoms of pelvic pain which we see. Frequently the patient will complain and we find nothing on repeated examinations. We may be inclined to dismiss the symptoms as being of psychogenic origin or due to pelvic congestion when the patient may have very early endometriosis.
5. *Spontaneous Regression*—In the treatment of endometriosis one must keep in mind the possibility of spontaneous remission of the

disease. Long before the menopause it is quite possible for the process to regress symptomatically as well as physically.⁹ This may be due to a building up of pressure in a cyst (ovarian or otherwise) so that the glandular structure is destroyed, rendering it unresponsive to cyclic hormonal stimulation. Also, there may be a proliferation of connective tissue which smothers the glands, so to speak. At any rate, it is possible for the areas of ectopic endometrium to degenerate and disappear or be replaced by scar tissue.

6. *Fever with Endometriosis*—Hunt¹ reports that often a low-grade fever may accompany endometriosis and be present even when it could not be accounted for by spillage or rupture of an endometrial cyst. This may give rise to some difficulty in differentiating the diagnosis from inflammatory disease of the pelvis. Endometriosis is not given as a cause of leucocytosis or of increase in the sedimentation rate.

Treatment

In treatment of endometriosis one must keep in mind the variations of the disease as well as the age of the patient and the number of children she has. Many patients have minimal or no symptoms and are operated on because of findings, such as ovarian enlargement. On the other hand, some patients are operated on because of acquired severe dysmenorrhea and no endometriosis is found.

We may divide the treatment into four parts:²

1. Some patients will either need no treatment or the symptoms are mild enough to be controlled by mild doses of sedatives or analgesics. Various workers find that 30-75% of patients can be treated this way.
2. *Endocrine Therapy*—With the use of endocrines relief is obtained by inhibition of ovulation or menstruation. The process may be brought to a standstill or the lesions may be reduced in extent. Pregnancy is often suggested as good preventive and therapeutic treatment for endometriosis. If pregnancy is not contemplated or desired, ovulation and menstruation can be inhibited by estrogens, androgens, or progestins. A state of pseudo-pregnancy with decidual reaction

can be produced by some of the newer progesterone derivatives.

Estrogens bring about anovulation, amenorrhea, and softening of the entire genital tract, and possibly of the areas of endometriosis.² Stilbestrol is used in doses of 5 mg. daily for 1 week, increasing 5 mg. each week until 60 mg. a day is being given. Equivalent doses of other estrogens may be used in the same manner.

Methyltestosterone in doses of 10-20 mg. daily by mouth inhibits ovulation; 25-50 mg. intramuscularly once or twice a week will accomplish the same. One must always be aware of the masculinizing potentialities of testosterone—acne, hirsutism, deepening of the voice, enlargement of the clitoris. These changes have been brought about by as little as 250 to 300 mg. per month orally or 150-200 mg. per month intramuscularly.

One method of inducing pseudo-pregnancy⁵ is with the use of norethynodrel (Enovid) orally 10 mg. daily for 2 weeks and increasing 10 mg. per day every 2 weeks until 40 mg. per day is being given. This inhibits ovulation and produces a secretory endometrium (which is not shed) with a decidual effect in the areas of endometriosis. The treatment should be continued for 6 or 7 months. Menstruation does not occur. Norlutin and Provera are likewise effective in inhibiting the menses but do not produce a decidual reaction. These are both oral preparations. Provera in 2.5 to 10 mg. doses is one of the most potent of the newer progestins.

Delalutin is an intramuscular form of progesterone which may be given 62.5 mg. weekly for 2 weeks, increasing by 62.5 mg. every 2 weeks until 500 mg. is being given in the 11th. and 12th. weeks.

3. *Conservative Surgery*—Factors concerned in surgery are age, marital status, number of children, or infertility status, and severity of symptoms. Conservative surgery means preserving the childbearing function when possible and desirable, or at least preserving one or both ovaries. Opinions differ as to the value of presacral neurectomy.

4. *Radical Surgery*—Radical surgery is indicated in women near the menopause or in

those a little younger who have their family. It is also indicated if the extent of the disease diminishes the chance of relief with conservative surgery. Radical surgery means removal of the uterus, tubes, and both ovaries.

5. *Irradiation Therapy*—Radium or x-ray will stop ovarian function and check recurring exacerbations. It does not remove the ovarian cyst or other masses which may continue to cause discomfort or disability. Irradiation should not be used in young women. It is not as flexible or adaptable as surgery.

Irradiation may be useful in two types of cases:

1. *Poor operative risks*—Radium, x-ray, and radon seeds have given considerable relief for many years. If sufficient relief is not obtained by x-ray, surgery is indicated.

2. *Post-operative activity*—If symptoms persist after operation x-ray may be useful.

Special Dangers—Crossen² cites some special dangers to watch for in treating endometriosis surgically. Extreme caution is necessary due to the extensive adhesions. These are not a simple agglutination of surfaces, as in inflammation, but actual tissue invasion into the wall of adjacent structures such as the small intestine, sigmoid, rectum, and bladder. If dissection is not very careful these structures may be torn. There is no line of cleavage. Sometimes dense cul-de-sac adhesions make removal of the cervix difficult, in which case it is better to leave it rather than risk perforation of the rectum. The cervix may be coned out from below if necessary.

Post-operative peritonitis and paralytic ileus are real dangers after surgery for extensive endometriosis. It is safer to drain all such cases post-operatively, as well as those in which endometriosis is suspected because of dense adhesions.

Two other things to bear in mind in connection with endometriosis are first, that spontaneous rupture of an endometrial cyst may occur, resulting in acute abdominal emergency; and secondly, that carcinoma of the ovary may develop in an endometriosis of the ovary.

Summary

1. Endometriosis has many variations. It may occur at an early age, or after the menopause.
2. Fertility may be good in the presence of endometriosis.
3. Endometriosis may be advanced, with pronounced findings on examination, and yet the symptoms may be few or absent. On the other hand, the symptoms may be severe in the presence of very few physical findings.
4. Endometriosis may regress spontaneously without treatment.
5. In a high percentage of cases endometriosis can be treated with mild analgesics, sedatives, and hormones.
6. Surgical treatment must be individualized and adapted to the particular needs of the patient under consideration. Age, marital

status, desire for children, and extent of the disease are factors governing surgical treatment.

7. Irradiation has a limited use in the treatment of endometriosis.

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PERICARDIAL BIOPSY

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There are numerous methods of classifying pericarditis, and once the presence of this condition has been established it is most important to attempt to categorize the condition etiologically, so that proper therapy may be brought to bear. This condition may be acute or chronic, fibrinous, serofibrinous, purulent, serosanguinous or hemorrhagic and may arise from any one of approximately eight etiological categories.¹

Except for acute nonspecific pericarditis, in which all of the facts of etiology are not yet at hand, pericarditis is secondary to disease elsewhere in the body, whether this disease be infectious, metabolic, neoplastic, traumatic, or allergic in nature.

Once the presence of pericarditis has been established there are two major problems which must be faced during the acute state—the establishment of specific etiology, and the prevention of cardiac tamponade or sub-

A readily utilisable procedure in establishing the specific etiology of pericarditis is recognized as real need. The need for establishing the presence or absence of a tuberculous etiology is particularly important and the established practice of aspiration and examination and culture of the material so obtained has definite drawbacks. Three cases are presented in which surgical biopsy of the pericardium was used in an attempt to establish the etiology of the pericarditis. Pericarditis of nonspecific etiology was proven in one case and tuberculous etiology in the other two cases.

sequent adhesive pericarditis. Where the secondary nature of the pericarditis is obvious, as in the case of uremia, myocardial infarction, etc., the problem of the pericarditis itself is not important. The situation in which the diagnostic problem generally arises is that in which the pericarditis is the presenting difficulty and in which etiologically indicated modes of therapy might be noncompatible or even diametrically opposed.

In this type of situation, the diagnostic puncture is the initial procedure of choice and serves the purpose of establishing the presence of effusion, the type of effusion, and in some cases the etiology. It will also, of course, be a means of relieving tamponade in many cases. However, where the etiology is not revealed by the initial one or two specimens of aspirate, (and this will be so in the majority of cases), it is fair to utilize a more revealing procedure if such is available. The need for such a procedure is intensified by the unpleasantness and danger inherent in repeated aspirations and by the relative limitations of diagnostic use to which one can put the material so obtained.

On the basis of a so far limited personal experience, and the somewhat wider experience of others, we are considering the use of a pleuro-pericardial window as a nearly routine procedure in all cases whose etiology remains obscure following one or two paracenteses.

Proudfit and Effler² in 1956 reported the results and application of pericardial biopsy and the formation of a pleuro-pericardial window in 16 cases. In these cases 10 were proven to be chronic pericarditis of nonspecific etiology. One case was proven to be tuberculous and one due to *Streptococcus viridans* by the use of tissue culture. Three cases of unusual etiology were revealed—a case of chylopericardium, carcinoma arising from the thymus gland, and one case of radiation fibrosis. In these cases a pleuro-pericardial window was formed to allow drainage of pericardial exudate into the pleural cavity and from thence it could be aspirated with greater ease. However, subsequent thoracenteses were few in number. There was no evidence of transmission of the disease to the pleura.

We have had two cases of acute pericarditis of unknown etiology thus far in which a definitive diagnosis was quickly made by pericardial biopsy. A third case yielded non-specific findings.

Case 1—F.S. A 49 year old Negro male referred with a history of increasing tiredness and shortness of breath for a period of two to three months. His symptoms had begun with a marked cough and subsequent chest x-ray films had shown progressive cardiac enlargement. Significant findings on examination included overall cardiac enlargement, heart sounds of poor quality, blood pressure in the range of 190/100

mm. Hg., ECG findings compatible with pericarditis with sinus rhythm, tachycardia and inversion of "T" waves in all leads except AVR. There was no evidence of pulmonary tuberculosis. Initial pericardial paracentesis yielded 300 ml. of serous fluid. Culture of this fluid yielded acid fast bacilli one month after the aspiration. Several subsequent paracenteses were performed and during the course of his illness the patient developed congestive heart failure and an extremely narrow pulse pressure. On the twenty-seventh hospital day a pericardial biopsy was made through a thoracotomy incision in the left fourth intercostal space under sodium Pentothal, nitrous oxide and ether anesthesia with intratracheal intubation. The patient developed temporary shock during the procedure but showed no postoperative complications. Thoracotomy drainage from the left pleural cavity was used but discontinued on the second postoperative day. A definitive diagnosis of granulomatous pericarditis of tuberculous etiology was reported 24 hours following the biopsy.

Case 2—R.B.H. A 33 year old Negro female admitted with a chief complaint of increasing dyspnea and swelling for two to three weeks. Examination revealed swelling of the left arm, bilateral pleural effusion, ascites and pedal edema. X-ray revealed marked overall cardiac enlargement and pericardial paracentesis yielded 500 ml. of grossly bloody fluid which did not yield acid fast bacilli. On the sixth hospital day pericardial biopsy with formation of a pleuro-pericardial window was performed using the same technique as in the previous case. Pathological report of granulomatous pericarditis, probably tuberculous in etiology, was reported from the biopsy specimen. Two thoracenteses were performed postoperatively with the removal of 1300 ml. of serosanguineous fluid.

Case 3—L.S.F. A 52 year old white female who began in May of 1958 to have recurrent arthralgia and was found in June of 1958 to have pericardial effusion. She showed mild anemia and leukocytosis to as high as 18,000 cu. mm. Chest x-ray films and fluoroscopy showed enlargement of the cardiac shadow compatible with pericardial effusion. The patient was treated with steroids with remission of symptoms while on this therapy, but prompt exacerbation at its termination. She was subsequently referred to the Medical College Hospital in Charleston where pericardial paracentesis and pericardial biopsy were both done. Fluid specimen from the paracentesis failed to yield a diagnosis on examination or culture. At operation the pericardium was found to be adherent to the epicardium and about 2 mm. in thickness. Pathological report showed "non-specific inflammatory changes." She was treated for tuberculosis for six months as a safety measure and is at present well and healthy.³

Comment: In the first case almost one month could have been saved in proving the

²Use of this case was kindly allowed by Dr. N. B. Baroody.

etiology of the illness if thoracotomy and biopsy had been performed after the initial one or two paracenteses. This patient is alive and has been doing fairly well on full anti-tuberculous therapy two and a half years after his hospitalization. Signs of constrictive pericarditis with congestive heart failure are still present but well controlled. The patient refused further surgery for the constrictive pericarditis. The second patient has done well since surgery on full anti-tuberculous therapy. She has not developed signs or symptoms of constrictive pericarditis or congestive heart failure.

Summary: Three cases of acute pericarditis in which etiology was proven by pericardial biopsy are presented. In view of the fact that

the proof of the etiology of pericarditis is difficult by the usual procedures except, perhaps in the unusual cases or purulent pericarditis, it is felt that the biopsy procedure is highly acceptable for more widespread diagnostic use. There are, of course, certain dangers inherent in subjecting the patient to thoracotomy but we feel that these dangers are in most cases outweighed by the time saved in making a diagnosis and thus being able to begin definitive treatment on what is usually a very dangerous disease process.

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THE EMERGENCY TREATMENT OF SEVERE BURNS

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The emergency treatment of severe burns can be regarded as a therapeutic triumph. Very few patients are lost in the first week, no matter how severe the burn, respiratory tract burns, which are infrequent, being an exception. Renal shutdown is rare and usually reflects inadequate treatment.¹

The objective is to restore and maintain blood volume. This is done easiest by first referring to one's favorite fluid calculator. Baxter Laboratories' calculator, based on the work done at Brooke Army Medical Center, is excellent.

Severe burns are second degree burns of over 30 per cent or third degree burns of over ten per cent of the body surface or burns involving the respiratory tract.

Remember that edema increases for two or three days, so even slight respiratory distress shortly after the burn will indicate a tracheostomy.² A history of prolonged smoke inhalation or burns of the face should put one on guard for this possibility.

As soon as this decision is resolved, the patient is weighed and taken to the operating room.

The emergency treatment of severe burns is usually successful if blood volume is maintained. The Brooke Army fluid calculator is recommended. Renal shutdown is rare and most often reflects inadequate treatment.

All patients are taken to the operating room on admission. Catheters are placed in an ankle vein and bladder. Sedation for the clean up is given by Demerol drip into the tubing. The burned areas are washed with Septisol and all blisters removed. No dressings are applied.

A cut-down is done at the ankle. A Mead-Johnson infusion catheter is inserted in the vein and fluid administration is begun. A Demerol (meperidine) drip is plugged in and as much given as needed for comfort during the clean-up of the burn.

The clean-up is a gentle washing with dilute Septisol. Blisters and dirt are removed and the areas washed with saline.

A Foley catheter is inserted. Blood is drawn for blood count, typing and hematocrit.

The patient is returned to her room—seventy-five percent of the time it is her room, her dress having caught fire. She is placed on a

Stryker or Foster frame, or in bed under a cradle.

Orders are now written. These will contain the calculated fluids, hourly urine output, tetanus prophylaxis and antibiotics, and sedation—Demerol or morphine as needed, in the tubing.

The desirable output is 10 to 20 ml. per hour for children under a year, 20 to 30 ml. per hour from one to ten years of age, and 30 to 50 ml. in older children.

If the child is under two years, give less electrolyte. Divide the fluid calculator's estimate in half and make up the difference with dextrose in water or give it half and half.

It is best to order nothing by mouth. Vomiting and distention may occur with any severe trauma. The intake is under complete control with the ankle catheter.

The urine output is the main guide for fluid requirements, but only for the first 48 hours.¹ After that, if things go well, an *ad lib.* oral in-

take is allowed. Potassium should be withheld for the first 48 hours, then added.

The tube is usually removed from the cut-down in four or five days. If the hematocrit does not show a high normal and if veins are scarce, one last transfusion is given before removal.

The Foley catheter is removed in four or five days, depending on the general condition of the patient and location of the burns.

If the patient comes to you and you don't expect to follow through with the grafting, it is best to send her on.

If the trip is a half hour or less, a small dose of morphine or Demerol intravenously and a clean sheet is all that is needed. If it is to take longer, do the cut-down and start some fluids—probably dextran in saline.

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Myasthenia gravis in one monozygotic twin. By Milton Alter, M. D. and O. Rhett Talbert, M. D. (Charleston) *Neurology* 10:793-798, August 1960.

The case of a 6-year-old Negro boy with myasthenia gravis is described. He had a normal, monozygotic twin in whom latent myasthenia could not be demonstrated by the curare provocation test. The implications of this example of discordance for heredity as an etiologic factor in myasthenia gravis are mentioned. Examples are cited of myasthenia in familial aggregates, where heredity might have played a part, but information in these reports is too incomplete to permit generalization about genetic mechanisms. No environmental factor was uncovered to explain the development of myasthenia in only one of the twins.

Geographic distribution of multiple sclerosis. Milton Alter, R. S. Allison, O. R. Talbert (Charleston) and L. T. Kurland. *World Neurology* 1:55-68, July 1960.

Development of the concept that multiple sclerosis is more common in colder regions than warmer zones

is reviewed. An epidemiologic survey in 2 comparable communities showed a prevalence of multiple sclerosis 2.4 times greater in the community that lies 1,200 miles farther north. The prevalence rates per 100,000 inhabitants were 13.5 for Charleston County, South Carolina, and 32.3 for Halifax County, Nova Scotia. Particular attention was paid to the formulation and uniform application of diagnostic criteria, and almost all the cases in each community were personally examined by the same team of investigators.

Age distribution of the patients was similar in each community, and age-specific prevalence rates were higher in Halifax in almost every age group. Possible reasons for the difference in prevalence include methods of locating cases, racial and other differences in population composition of the two communities, various clinical features, and genetic factors. However, none of these variables was considered to be of sufficient magnitude to explain the difference in prevalence. The present study supports the view that the prevalence of multiple sclerosis does vary with geographic latitude. The explanation of this promises to aid in clarifying the etiology of multiple sclerosis.

WHAT TO TELL THE PATIENT AND FAMILY IN TREATING INJURIES OF THE UPPER EXTREMITY

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The patient and family usually think all broken bones should heal perfectly straight and that all injured joints should move perfectly. This is often not the case. A great deal of disappointment can be avoided if the interested parties are told at the beginning what one might expect in the case of a fracture, a dislocation, or a severed tendon. If an explanation can be made as to how and why the result may not be perfect and what complications might arise, the patient and family will be mentally prepared for the results or complications.

Shoulder

In a fracture of the neck of the humerus, tell the patient that a stiff, painful shoulder is the thing to be avoided. I have seen a good number of painful stiff shoulders following a simple Colles fracture. Overhead shoulder exercises were not stressed. In an arm fracture, overhead shoulder exercises should be carried out several times a day. Demonstrate and start gravity exercises even at ten days and stress overhead exercise quickly, sometimes even before you are certain of bony union. The reason you will not see a refracture after light union is that the patient will guard against pain. I have never seen a refracture of the neck of the humerus, even if overhead exercises are started at the third or fourth week. The thing to fear in an injury about the shoulder in a patient over 45 years is a painful stiff shoulder. Tell the patient the more the shoulder moves, the less painful it will be, and the less it moves, the more painful it will be.

Elbow

This is the area in which we see the most misunderstanding in the minds of the patients and families. The anterior capsule of the elbow is naturally slack in flexion in the uninjured elbow. After injury, be it a supracondylar fracture or dislocation, nature, in her healing, thickens and ties this capsule so that complete extension will not take place, even in young

In treating injuries of the upper extremities it is wise to have a talk with the patient or the parents of the patient and tell them what results are to be expected and what complications might arise. For example, in a fracture of the elbow limitation of motion in extension is very common.

children. After a perfectly reduced and treated supracondylar fracture, there is often a residual flexion contracture of the elbow of 20 to 40°, or more. After dislocation of the elbow in the adult, or even a fracture of the head of the radius, this lack of full extension may be 40 to 80°, i. e., the patient may be able to extend the elbow just a few degrees beyond a right angle. If all this is explained in advance to the parent or patient, the question, "Why can't John straighten his elbow?", or "Why can't I straighten my elbow?" will not arise with such excitement as it does in the case when no explanation has been made. While we are talking about the elbow, we should bring up the growth factor in children. In a good many cases of supracondylar fractures, even those well reduced and treated, the lateral epiphysis of the humerus outgrows the medial, and some degree of gunstock deformity develops in the next few years. Tell the parent this often happens and you wish to observe the child for several years to see if this comes about. Tell the parent the supracondylar fracture is one of the fractures most often followed by complications.

Forearm

In fractures of the shaft of the radius and ulna, bowing may be an embarrassing development. Bowing usually takes place towards the extensor side due to the fact that the radius is already bowed this way normally, and secondly, the flexor muscles, which are much stronger than the extensors, act as a tightening string on the bow to increase the bowing.

Explain all this to the parents. Take an x-ray picture at ten days or make the cast "bivalve" and remove the arm and look at the alignment. If bowing has occurred, it will be easy to correct.

Wrist

Fractures usually give little trouble. There are exceptions.

In a comminuted fracture of the radius at the wrist, radial deviation often takes place. Tell the patient this may happen. Insist on the patient using a sling. When the arm and cast are held without a sling, the strong thumb muscles and muscles attached to the radius accentuate this radial deviation.

Stress finger motion. A stiff finger is more disabling than stiffness of any other joint. Often a patient will not move the fingers since this causes pain. Before you reduce the Colles fracture, tell the patient you wish him to start moving the fingers as soon as he awakes. The movement you wish most is flexion of the interphalangeal joint. Gripping a ball is not nearly as effective as trying to grip a pencil. The metacarpo-phalangeal joint motion is often easy to get started—the interphalangeal is difficult. Since it is not natural to move the fingers when it causes pain, you may have to see the patient often—even every day or so—and entreat, beg, or maybe even bully him into moving the fingers. In a Colles fracture of the aged, it is usually wise to place a splint or cast on with wrist in neutral, not attempting

to reduce the fracture, but stressing finger motion.

Finger Injuries

Injuries of the tips of the fingers and the metacarpals do not give the doctor or patient much disappointment.

The injuries of the proximal and mid phalanges are a far different story. They often give great disappointment. A comminuted fracture of the proximal phalanx may heal with flexion contractures of the interphalangeal joints. The flexor tendon may be involved. If the flexor tendon of one finger does not have full excursion of motion, the uninjured fingers are often left with limitation of motion or some flexion contractures of the interphalangeal joints. Explain all this to the patient. To make it dramatic, tell the patient a surgeon will probably have less residual disability with a fracture of the femur (the largest bone in the body) than he would with a comminuted fracture of the proximal phalanx of his index or middle finger.

Summary

Patients and family are usually very reasonable if they know what to expect in injuries. It will often save the physician embarrassment and the patient disappointment if he will simply explain to the interested parties the possible outcome and possible complications in the different type injuries of the upper extremities.

Autogenous vein grafts and Teflon grafts as small vessel prostheses, R. R. Bradham and D. B. Nunn. (Charleston) Arch. Surg. 81: 136-139, July 1960.

The purpose of this study was to determine the merits of autogenous veins and Teflon tubes as replacements for arteries with an external diameter of 5 mm. or less. The Teflon was chosen because of its proved superiority as an artificial prosthesis for large and medium arteries. The vein grafts were used as they are autogenous tissue which will retain viability. Braided crimped Teflon grafts and autogenous femoral vein grafts measuring 25 mm. in length and 5 mm.

in external diameter were used to bridge the defect in femoral arteries of adult mongrel dogs after excision of a segment 20 mm. in length. Patency of the grafts was determined by palpation of the femoral pulsation daily and by lumbar aortograms at two months after operation. All animals were killed when grafts became occluded or at six months after operation. Seven out of fifteen vein grafts remained patent. Five out of ten Teflon grafts remained patent. The merits of the two types of grafts used are discussed. Observations were made regarding the factors related to thrombosis in these small arteries.

HEAD INJURIES

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In evaluating any traumatic injury certain specific details pertaining to the accident are indispensable. In head injuries the following information establishes the basis for subsequent action: (1) time and nature of accident, (2) mechanism and the character of the object with which it made contact, (3) site of maximum injury to the scalp and skull, (4) the clinical condition of the patient, (5) changes in the conscious state since injury, and (6) estimate of neurological dysfunction and recognition of changing neurological signs.

Attention should be directed initially to the adequacy of the cardiorespiratory mechanism. Every effort should be made to insure satisfactory pulmonary ventilation. When respiratory exchange is hampered by a combination of thoracic and cerebral injuries, tracheostomy may be effective in providing an adequate airway. Shock, *per se*, is seldom produced by a head injury alone. If shock is present, further study should be made to rule out the presence of a fracture, a dislocation, or a hidden hemorrhage.

Because of the rich blood supply lacerations of the scalp seldom become infected. Lacerations should be cleaned and loosely sutured. At the time of suture, however, one should explore the wound with the finger for any possible fracture or depression of the skull.

Fractures of the skull may involve either the base or vault and can be divided into simple, compound, linear, comminuted or depressed. The simple linear fracture usually requires no specific therapy except when the fracture extends into the middle ear. Antibiotics should be given in these cases. Simple comminuted or depressed fractures are not surgical emergencies but should be corrected if the cosmetic result is unacceptable or if there is associated cerebral dysfunction. Compound fractures should be promptly elevated and the wound closed. A convulsion shortly after injury suggests contusion or laceration of the brain. No specific treatment is indicated unless further attacks occur and then proper anti-

In evaluating any traumatic injury certain specific details pertaining to the accident are indispensable. Attention should be directed initially to the adequacy of the cardiorespiratory mechanism. Compound fractures should be promptly elevated and the wound closed. The presence of a lucid interval with subsequent unconsciousness is strongly suggestive of intracranial hemorrhage. In patients who show signs of progressive deterioration the presence of an expanding lesion such as an epidural or subdural hematoma should be considered.

Intelligent nursing care and careful observation with institution of appropriate treatment will salvage some of these victims.

convulsant measures should be instituted. An attack of decerebrate rigidity is always a grave sign indicating brain stem damage. Dilated and fixed pupils are also grave signs and give a poor prognosis.

The presence of a lucid interval following a head injury, where a patient is dazed, recovers consciousness, and later becomes drowsy and comatose, is strongly suggestive of intracranial hemorrhage such as epidural or intracerebral hemorrhage. Children, shortly after having a cerebral concussion, often show intermittent drowsiness, headache, and vomiting for several hours after injury followed by complete recovery. The persistence of such symptoms, however, should be looked upon as being caused by intracranial hemorrhage until disproven.

Roentgenograms of the skull are advisable unless the patient is in shock or has other serious injuries. The patient should be examined by x-ray before leaving the hospital for medico-legal purposes. The question of lumbar puncture is somewhat equivocal. In perusing the literature I find that most neurosurgeons state that it may be of diagnostic significance, particularly to rule out the presence of blood in the subarachnoid space and to confirm increased intracranial pressure.

If the patient is conscious and complains of

discomfort mild anodynes are given as indicated. Extreme restlessness must be controlled to prevent the danger of exhaustion as well as further increased intracranial pressure. The barbiturate derivatives and paraldehyde usually serve the purpose quite well. Lately, some of the tranquilizers have been used to good advantage. Early fluid intake and nutritional requirements in comatose patients are first supplied by intravenous fluids. However, after two or three days this is discontinued and feeding is begun through a small plastic gastric tube. In an adult we usually give 2000 ml. of fluid containing 2000 Calories per twenty-four hours in divided doses. In addition, to this, other medication can be instilled through the tube quite well.

The presence of blood or spinal fluid within the ear canal usually ceases within a few days but antibiotics should be given prophylactically for the prevention of meningitis.

Management of delirium tremens—Preliminary observations with trifluoperazine. Naseeb B. Baroodi, Jr., M. D. Waddy G. Baroodi, Jr., M. D., and Adrian Reed, M. D. and Walter R. Mead, M. D., (Florence, S. C.), J.A.M.A. 172:1284-1287, March 19, 1960.

Delirium tremens, a fairly common syndrome resulting from prolonged drinking, usually comes on after the patient is detoxified, and has a reported mortality of from 5-15%. The differentiation between true delirium tremens and alcoholic hallucinosis may be difficult. The most reliable differentiating features are hyperkinesia, hyperexcitability and coarse tremor, in addition to those symptoms observed in simple alcoholic hallucinosis.

Because of its reported antihallucinatory effect, trifluoperazine (Stelazine) was administered to 23 alcoholic patients with hallucinosis or delirium tremens either present or indicated by past history. Trifluoperazine intramuscularly was found to be the most effective route of administration. Of the 23 patients, 13 had no hallucinations. Of the 10 who hallucinated, none was disturbed for more than 3 days and 7 were oriented in less than 3 days, with a total average duration of delirium tremens being only 1.6 days.

The basic cause of delirium tremens is not known, however, many factors related to alcoholic intake and altered metabolism have been identified and investigated. These include intake and absorption of carbohydrates and vitamins, mineral deficiencies, par-

Antibiotics also should be given in cases of cerebrospinal rhinorrhea.

In patients who show signs of progressive deterioration, which is manifested by changes in the vital signs, the presence of an expanding lesion such as an epidural or subdural hematoma should be thought of; particularly is this so if there are localizing neurological signs. These should be explored promptly. Late symptoms may be indicative of either a chronic subdural hematoma or a chronic subdural hygroma.

Intelligent nursing care and careful observation with institution of appropriate treatment will salvage some of these tragic victims.

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particularly magnesium, cerebral edema related to the acute alcoholic state, previous liver disease with altered hepatic function and other factors yet unidentified. Current experimentation indicates that the basic defect in patients with delirium tremens may occur at the cellular level with alterations in structure and biosynthetic mechanism of the brain cells and cellular membranes.

The essentials of management of patients with delirium tremens is directed towards correction of the patho-physiologic factors involved. Administration of an electrolyte solution containing glucose, magnesium and large doses of vitamins, especially thiamin, is necessary. Insulin once given as a part of accepted therapy is now considered of little physiologic use. Steroids are of value in supporting the extreme physiological stress usually encountered. Diuretics may diminish the hyperhydremic state, particularly cerebral edema. Tranquilizers, especially the phenothiazines, have revolutionized the treatment of alcoholism. Although they are useless in the acute phase, they are of value in controlling the acute agitation and restlessness during withdrawal. We have no diminution in the incidents of hallucinosis following their use.

We have found trifluoperazine, administered intramuscularly in doses of 2 mg. 4 times a day, to be an effective therapeutic measure when added to the accepted treatment of delirium tremens. In a limited group of patients studied, no toxic reactions or side effects were observed.

FOREIGN BODIES OF THE EAR, NOSE AND THROAT

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Foreign bodies of the ear, nose and throat occur very frequently for in this small anatomical area are five orifices which readily receive extraneous matter.

The external auditory meatus is a skin-lined canal approximately $1\frac{1}{2}$ inches long and $\frac{1}{4}$ to $\frac{1}{2}$ inch in diameter. Foreign bodies occur anywhere along the canal, but are most commonly wedged in the isthmus which is the narrow junction between the outer membranous third and the inner bony two-thirds of the canal. Fortunately, most foreign bodies become impacted before reaching the tympanic membrane, but occasionally rupture of the ear drum and penetration of the middle ear occurs. The middle ear is an air filled space approximately the size of an aspirin tablet and containing three small articulating ossicles which bridge the space between the tympanic membrane and the inner ear. Dislocation of the ossicles or penetration of the inner ear seldom happens. Either of these unfortunate incidents will result in severe conduction deafness from loss of continuity in the ossicular chain and total deafness and possible meningitis from penetration of the inner ear. Fracture of the thin bony roof of the middle ear may occur in cases of blind, unskilled attempts at removal of foreign bodies in this area. Laceration of the meninges usually accompanies this misadventure and spinal fluid escapes from the ear, setting the stage for meningitis and possibly death, unless immediate, intensive and prolonged treatment is carried out. Occasionally high velocity projectiles may tear through the temporomandibular joint or the mastoid and lodge in some portion of the ear.

Symptoms of a foreign body in the ear may be loss of hearing, pain, discharge, tinnitus, reflex cough, vertigo and limitation of motion in the temporomandibular joint. Usually the examiner is presented with accurate information regarding the type of foreign body and the time of insertion, but occasionally only the symptomatology is given and the foreign body is discovered during routine ear examination.

Foreign bodies of the ear, nose and throat occur most frequently in the pre-school young and the edentulous elderly. Diagnosis may be very simple or extremely difficult. A thorough history and physical examination supplemented at times by fluoroscopy and x-ray examination will usually give the diagnosis. Foreign bodies should be removed as soon as possible under local or general anesthesia. Perforation of a hollow viscus and subsequent cellulitis is the most dreaded complication.

Occasionally foreign bodies will not cause pressure, blockage or irritation and may be entirely asymptomatic. Living insects frequently enter the ear and their vigorous movements may give terrifying noises as well as pain.

Removal of any foreign body of the ear is mandatory. General or local anesthesia may be required; this depending somewhat on the cooperation of the patient, the degree of impaction of the foreign body and the dexterity and skill of the operator.

Instruments most useful for removing foreign bodies of the ear are various hooks and suction tips. Use of forceps is likely to push the foreign body further in, often complicating what otherwise might be a simple removal. Gentle syringing may be successful in a non-impacted foreign body, but hygroscopic foreign bodies, such as beans or peas, may complicate by swelling even tighter, making removal extremely difficult. Using alcohol instead of water will prevent this exasperating situation. Instrumentation must be meticulous, or lacerations and other soft tissue damage will result. Bleeding is controlled by packing the ear canal firmly with gauze. Infection is eliminated or prevented by chemotherapy or antibiotics. The patient is followed until normal physiology is restored.

Foreign bodies in the nose are extremely common in young children. They usually enter through the anterior nares, but occasionally they enter through the posterior choanae via

the nasopharynx during bouts of sneezing, coughing or vomiting.

Symptoms may be pain or sneezing initially, followed by discharge, at first serous or serosanguinous, but later purulent and malodorous. Foreign bodies are rarely bilateral. Frequently a child is presented with a unilateral foul purulent nasal discharge that has failed to respond to intensive and prolonged treatment with antibiotics. Removal of the foreign body will give a dramatic cure.

Before attempting removal of a nasal foreign body, thorough shrinkage of the mucous membrane by several applications of a topical vasoconstrictor such as 0.25% phenylephrine is desirable for maximal visibility and minimal bleeding. General anesthesia, or topical anesthesia with maximum restraint of the heavily sedated patient is mandatory, because this is no place for a moving target. Thorough inspection of the nose will usually reveal the foreign body in the common meatus along the floor of the nose, wedged between the turbinates and the nasal septum. The foreign body can usually be removed anteriorly, this depending on the type of foreign body and the number of previous unsuccessful attempts at removal. If the object is located extremely deep in the nose, it may be necessary to push it into the pharynx and recover it from the pharynx through the mouth. This requires that the patient be in an exaggerated Trendelenburg position to minimize aspiration. Removal of nasal foreign bodies is usually accomplished with hooks and a large Pilling type suction apparatus. Ordinarily no follow up care is necessary after removal of a nasal foreign body.

Foreign bodies of the mouth are usually removed by the patient or members of his family. Foreign bodies in the tonsillar area and beyond usually require the skill of a physician for removal. They are less common in the pharynx than elsewhere, because foreign bodies do not impact in the pharynx unless they have a sticking quality such as pins, sandspurs, small fish bones, etc. These objects may be found in the fauces, tonsils, base of tongue, valleculae, or pyriform fossa. Occasionally a foreign body will be coughed or sneezed or vomited from the pharynx into the nasopharynx and may lodge between the

eustachian eminence and adjacent structures. Foreign bodies in the throat cause pain and sticking that is aggravated by swallowing.

Foreign bodies around the base of the tongue and the oropharynx can usually be found by routine tongue depression and direct inspection. Various forceps are of value in removal. Objects that lodge in the nasopharynx may be visualized by elevating the soft palate with a retractor, and viewing the object directly. The postnasal mirror or electric nasopharyngoscope will give indirect visualization of the foreign body. It is removed by visualization and grasping with the appropriate forceps. Foreign bodies of the hypopharynx may be visualized indirectly with a laryngeal mirror and removed with curved forceps. Many foreign bodies of the hypopharynx are best removed by direct visualization with a laryngoscope or esophagoscope and removal with straight alligator forceps. Copious secretions in this area requires good suction. Pharyngeal movements, such as swallowing and gagging must be minimized by reassurance and heavy sedation and adequate topical anesthesia. General anesthesia is to be avoided for removal of foreign bodies in this area because dislodgement of the foreign body may occur during the excitement period and retching with aspiration and air way obstruction may necessitate tracheotomy or bronchoscopy. Small children are best "mummied" with a sheet and restrained by assistants, including a good head holder.

Foreign bodies that pass beyond the pharynx enter either the digestive or respiratory tract. The pharynx is a common pathway for food, beverages and air. Inferiorly it divides into two passages whose entrance is protected by a sphincter. The entrance of the esophagus is a purse string muscle, the cricopharyngeus. Inferiorly is another sphincter, the cardia, at the entrance of the stomach. In between are two indentations caused by pressure from the left bronchus and aortic arch. These indentations may arrest foreign bodies in the esophagus that have bypassed the cricopharyngeus and upper cervical esophagus. Most foreign bodies occur in the cricopharyngeal area or upper cervical esophagus. Coins are most common in children and bones in adults. Large

boluses of food especially meat, may lodge in the esophagus of hasty eaters, the edentulous elderly, or the inebriated. Patients with old strictures of the esophagus from caustic ingestion many years before, may repeatedly come in for removal of food impactions at the stricture site.

Symptoms of a foreign body of the esophagus depend on the type, point of obstruction, and the temperament of the patient. Dysphagia, salivation and regurgitation occur if obstruction is complete. Pain and sticking are common with sharp objects. Pain may be referred to the back or sternum.

Diagnosis of foreign body of the esophagus is suggested by history, supplemented by x-ray examination and either confirmed or disproved by esophagoscopy. If the object is non-opaque, the point of obstruction may be demonstrated by fluoroscopy while the patient swallows a small bolus of cotton impregnated with barium.

Esophagoscopy for removal of foreign bodies may be an urgent procedure if obstruction is complete, pain usually severe, or party wall pressure on the trachea sufficient to embarrass the airway. Ordinarily, however, circumstances will permit careful planning for the performance of an orderly procedure.

Usually esophagoscopy is performed under local anesthesia with maximum sedation in adults. Children and some extremely apprehensive adults require a general anesthesia. A protein digestant, papain, may successfully digest and break up an impacted bolus of meat, making esophagoscopy unnecessary.

Perforation of the esophagus is a dreaded complication which may result when sharp objects are swallowed or during their removal, especially open safety pins with the sharp point trailing. Any foreign body that lodges between the pharynx and the cardiac sphincter must be removed by esophagoscopy and extraction of the foreign body with forceps. Objects that pass beyond the cardiac sphincter usually will pass through the entire gastrointestinal tract without harming the patient. However, close observation of the patient is required and surgical intervention is immediately instituted at the first sign of perforation and ensuing peritonitis. As soon as the

foreign body is recovered from the stool, the patient is dismissed. Foreign bodies may rarely be impacted at the ligament of Treitz between the duodenum and jejunum and require surgery for removal.

Foreign bodies of the larynx may completely obstruct the airway and require immediate removal for survival of the patient. Lesser degrees of laryngeal obstruction will give hoarseness or aphonia. Aspirated sandspurs frequently lodge in the larynx. Direct laryngoscopy and removal with forceps is performed preferably under local anesthesia. If a general anesthesia is required, the operator must be prepared to do a bronchoscopy or tracheotomy if needed.

Diagnosis of a foreign body in the tracheobronchial tree may be extremely difficult or relatively obvious. Aspiration of a foreign body usually gives an initial violent coughing episode, followed by a quiescent period of a few hours or days, depending on the type of foreign body and the degree of irritation and blockage. Nuts and vegetable matter are particularly offensive to the tracheobronchial tree, and delay in seeking medical care often produce a critically ill febrile dehydrated patient with bronchopneumonia and atelectasis.

Diagnosis is made from history and auscultation which may reveal wheezing, absent breath sounds, or coarse rales. Fluoroscopy may reveal cardiac shifting if obstructive atelectasis is present. If obstruction is complete, atelectasis results. If there is obstruction only during expiration, emphysema will result.

Treatment demands visualization and removal with various forceps during bronchoscopy. Most foreign bodies enter the right main bronchus because it is more directly in line with the trachea. The operative procedure is performed under local or general anesthesia and the patient is followed until asymptomatic and until a normal chest roentgenogram is obtained. Any bizarre chronic pulmonary infection demands the consideration of a foreign body and bronchoscopy may reward the examiner by uncovering an unsuspected foreign body and curing a patient whose plight seemed hopeless. Any pulmonary symptom from chronic cough to

frank hemoptysis may be on the basis of a foreign body.

Bronchoscopy in small children demands minimal instrumentation and trauma to avoid laryngeal edema which, if severe enough, will require a tracheotomy.

Foreign bodies of the ear, nose and throat

may range from trivial insignificance to tragic demise. Symptoms may be absent or multiple. Diagnosis may be simple or extremely difficult. Treatment may be elementary or extremely complex. Complications may be absent or fatal.

EMERGENCY TREATMENT OF POISONING IN THE HOME

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There are some 250,000 toxic or potentially toxic trade name products on the consumer market. Hence, a common distress telephone call that we all get often is, "Doctor, I just found little Johnny on the floor drinking a bottle of Brand X!". The first reaction of the parent is always panic. Let us look at some of the facts about poisoning in the home.

Poisoning was listed as the cause of death in 5,883 cases in the United States in 1953.² Approximately 150 to 200 cases of poisoning are treated for every death. A large majority of these cases occur in the home as industry becomes more and more safety conscious. Most of these cases are accidental and most cases involve children. Most children who are accidentally poisoned are in the age group under 3 years, the exploring, inquiring toddlers. By far the majority of accidental home poisonings are with medicines, aspirin leading the list by a large margin. This is in part due to the fact that almost every home with a child has a bottle of tasty, flavored, children's aspirin whose taste tempting goodness has been extolled by Mommy, Daddy, and an assortment of TV announcers. One study of accidental poisoning in children revealed that most of the children who take poisons accidentally are active and curious, most substances ingested are easily accessible to children, and parents do not realize that a large number of household substances are poisonous.¹

After you have received the panic call and

Poisoning in the home is one of the most common reasons for distress telephone calls. A calm approach and proper identification of the ingested poison are important. The ingested poison should be removed by induction of vomiting or gastric lavage except with certain types of poisons.

There are numerous chemical insecticides now on the market. Many of these are very dangerous. They must be identified properly so that proper treatment can be instituted when poisoning occurs.

have calmed the frantic parent, what comes next?

First, the substance ingested should be identified and amount taken determined, and its toxicity investigated. Fifty per cent of the substances ingested by children will be harmless.³ Some poisons also have specific antidotes, so they must be properly identified. There is a good list of household products with the toxic ingredients listed in the back of the *Physician's Desk Reference*. If necessary, you can call one of the nearby poison control centers for information on almost any household or industrial product.

Knowing what you are dealing with, it is possible to determine what treatment will be necessary. The first step is always to remove the patient from the poison or remove the poison from the patient.

If the poisonous substance is on the skin it should be washed thoroughly with soap and water. This is especially important in certain

types of insecticide poisoning. Contaminated clothing should be discarded, but the patient should be kept warm and quiet. Patients who are convulsing or who are near convulsion should be kept in a quiet room, free from jarring noises and panicky bystanders.

Most authorities feel that it is best to advise the parent to induce vomiting immediately unless the poison is a caustic substance or a petroleum distillate.² This may be done by gagging with a finger. If this is unsuccessful, syrup of ipecac in adequate dosage will induce vomiting. Most authorities do not advise subcutaneous injection of apomorphine unless you are absolutely sure you are not dealing with a depressant poison.

If you read two articles on poisoning, you will always see two diametrically opposed views as to whether it is better to use emetics or gastric lavage for removing ingested poisons. One recent study of salicylate poisoning revealed that a much more significant amount of ingested material was removed by ipecac-induced vomiting than by gastric lavage.⁵ Certainly induction of vomiting is contra-indicated in poisoning from corrosive materials and is probably not wise in poisoning by petroleum distillates. Some believe that the pneumonia resulting from ingestion of petroleum distillates is caused by aspiration, and inducing vomiting or gastric lavage would increase the danger of aspiration.² Others, however, feel that pneumonia results from the fact that the ingested petroleum distillate is excreted through the lungs.

The danger of aspiration in an unconscious or semi-conscious patient is great, therefore many authorities question the advisability of gastric lavage in these patients, even for the removal of barbiturates from the stomach. The most important thing to remember with an unconscious patient is to keep the air way patent.

Having gone through these general symptomatic measures, specific treatment can be instituted if necessary. Fortunately, with most accidental poisonings in the home, ridding the patient of his poison is all the treatment necessary. All patients should be observed, however, for the various toxic effects of what may have been absorbed. Often this can be done at home, but an overnight stay in the hospital is

certainly wiser than a near brush with death. Every office should be equipped with the necessary materials for gastric lavage and for treatment of emergency poisonings unless such equipment is readily available at a nearby hospital. A good list of the necessary materials can be found in Von Oettingen's book, *Poisoning, A Guide to Clinical Diagnosis and Treatment*.⁶

In the last 20 years thousands of chemical insecticides have been poured onto the market, just as have new drugs. Most of these are more toxic for insects than for humans, but many are hazardous to humans and especially children. Many of them can be absorbed in dangerous amounts through the skin or breathed in through the lungs. There is also a baffling array of trade names about as complicated and catchy as drug names. We will consider some of these and the treatment of poisoning by them.

There are two general groups of dangerous insecticides, the organic phosphates and the chlorinated hydrocarbons. If suspected poisoning occurs, the patient should be removed from the area of poisoning, and the clothing removed and skin washed thoroughly with soap and water, and the patient should be kept warm and the airway patent.

The organic phosphates in common use are as follows: Chlorothion, Co-ral (Bayer 21/199), Demeton, Diazinon, Dipterex, Dyston, EPW, Guthion, Korlan, Malathion, Methylparathion, Parathion, TEPP, Thimet, and Trithion. These are severely toxic and dangerous materials even in small amounts. They are dangerous to the operator who is applying them, but there is also a toxic residue left. These materials may be absorbed through the skin.

Symptoms of organic phosphate poisoning are the same as the effect of the drug muscarine and include salivation, agitation, miosis and muscle cramps. In severe poisoning the symptoms progress to dyspnea due to an asthmatic-like bronchial spasm, convulsions, and vascular collapse. Atropine is the specific antidote to the organic phosphate group of poisons. This should be used in large doses, preferable intravenously, in adequate dosage to relieve the muscarine like symptoms. The

best way to judge dosage is to give atropine until the pupils begin to dilate. Oxygen and other supportive measures should be used, and of course all of the skin should be washed with soap and water to remove poison which may be absorbed through the skin.

The chlorinated hydrocarbons are very commonly used as household and farm insecticides. They include the following trade name products: Aldrin, BHC, Chlorodane, DDT, Dieldron, Dilan, Dimite, Endrin, Heptachlor, Lindane, Methoxychlor, Corex, DDD, Rhothane, Tedion and Toxaphene. Some of these may be absorbed to some extent through the skin, but most are fairly harmless unless either breathed in or ingested. Since these materials are usually sprayed as insecticides, breathing in the droplets is a frequent cause of toxicity in children.

The symptoms of poisoning by chlorinated hydrocarbon are excitement, dyspnea, nausea,

and vomiting. Severe poisoning will lead to convulsions which are very difficult to control. The specific treatment of poisoning by chlorinated hydrocarbons consists in controlling the symptoms. Convulsions are best controlled by conventional barbiturate drugs and of course as much of the poison should be removed as possible by washing the skin and in cases of ingestion by gastric lavage or induction of vomiting.

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All of the preceding papers in this number were presented at the Frank Hilton
McLeod Seminar, Florence, S. C., March 17, 1960.

MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

Anemia

DALE GROOM, M. D.

Department of Medicine

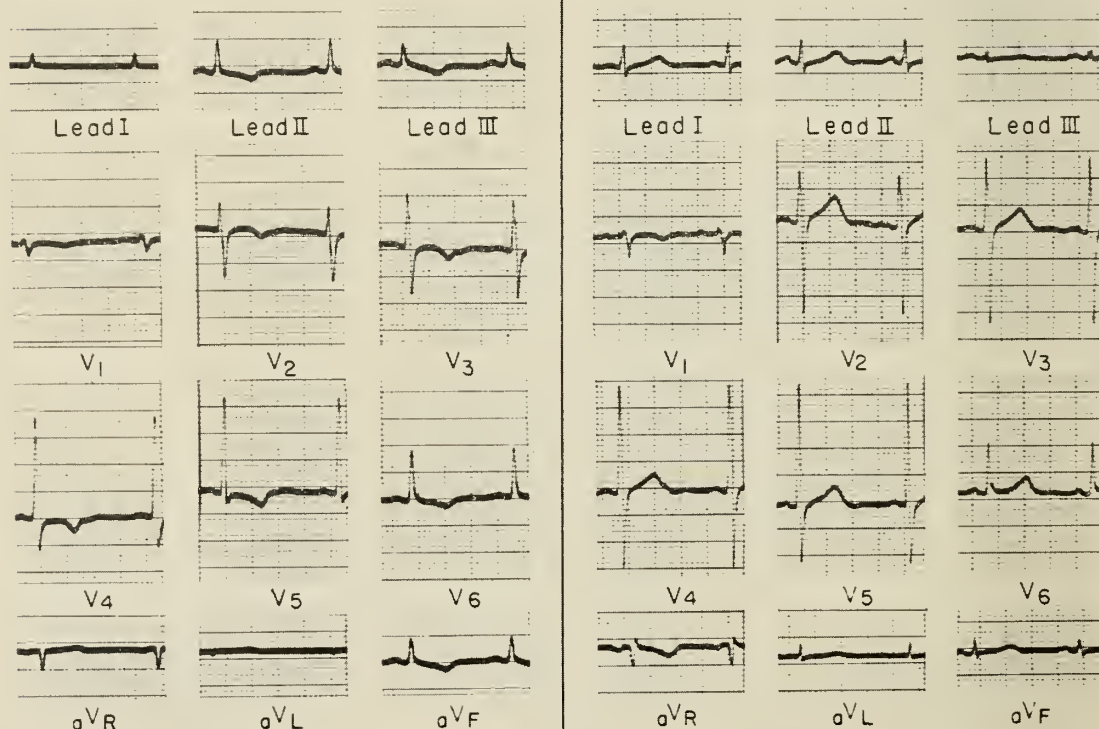
Case Record—The effects of extreme chronic anemia are illustrated in this case of a 64-year-old Negro admitted on the Medical Service because of profound weakness. Despite progressive weakness, dyspnea and weight loss for several years, and ultimately episodes of syncope, she had not sought medical care until completely incapacitated.

Her red blood cell count on admission was 380,000, leukocyte count 1,650, hemoglobin less than 1.5 grams per 100 ml. and hematocrit 4 volumes percent. A diagnosis of pernicious anemia was established on the basis of these values plus typical anisocytosis and poikilocytosis of the red cells, gastric achlorhydria,

and a strongly positive Shilling test. Remarkably, at no time did she show frank congestive heart failure; her heart was only slightly enlarged, the blood pressure persistently low (90/50) and hemic murmurs of grade II intensity were a constant finding.

Following institution of vitamin B-12 therapy her reticulocyte count rose to 10% within one week. Additionally she was given two blood transfusions, folic acid and an iron supplement. When the electrocardiogram on the right was made at a follow-up examination five months later her hematocrit had risen to 36.

Electrocardiograms—The prominent difference between the admission tracing (left) and the subsequent normal one is in the T waves. Initially inverted in all precordial leads, they became upright following treatment. Also with correction of the anemia the minimal S-T depressions ($V_4, 5$) disappeared and there was some increase in voltage of the QRS complexes, noted chiefly in the precordial leads, more than can be accounted for by electrode



placement or the slight shift in axis toward a more horizontal position.

Both tracings show a sinus rhythm at a rate of about 75 with normal P waves and AV conduction throughout.

Discussion—Although anemia is known to alter the electrocardiogram there is little agreement among observers as to specific abnormalities produced by it, perhaps because the effects are so variable from one individual to another. Opinions range from no significant changes to decrease in amplitude of T waves to actual change in direction of T waves and depression of S-T segments, reduction in voltage of QRS complexes and impairment in AV conduction. Hardly any electrical changes could be less specific than these ascribed to anemia. They are of clinical interest primarily because they may mimic the abnormalities of coronary and myocardial disease from which they must be differentiated.

Certainly this severe degree of chronic anemia in a patient without evidence of primary heart disease should bring out any electrical alterations caused by a deficiency of circulating hemoglobin. Primarily it is repolarization which is altered here, with perhaps some change in voltage of depolarization. In contrast to the localized ischemia of coronary insufficiency, the entire myocardium is affected. The minimal S-T depressions and T wave inversions are of course consistent with ischemia.

It is difficult to understand how the myocardium can function either electrically or mechanically with a blood supply having less than one-tenth the normal oxygen carrying capacity, particularly in the face of the high cardiac output characteristic of anemia. On the other hand, the decrease in blood pressure and reduction in viscosity of the blood with anemia both tend to decrease the work load of the heart. Moreover, there is a concurrent acceleration of blood flow in the coronary as well as the systemic circulation, the net effect of which is greater utilization of the limited number of red blood cells available. Apparently coronary circulation can increase considerably unless there is pre-existing occlusion of significant degree. In that event evidence of localized ischemia might be expected, perhaps accounting for some of the variability of the electrocardiogram in anemia.

Dr. Groom's book *Clinics in Electrocardiography* is available through the Medical College Book Store, or from the Publisher, Charles C. Thomas, Springfield, Ill.

POSTOPERATIVE COMPLICATIONS

II. Acute Gastric Dilatation

R. RANDOLPH BRADHAM, M. D.

Assistant Professor of Surgery

Acute gastric dilatation is a condition in which there is excessive enlargement of the stomach occurring suddenly in the early postoperative or post-trau-

matic period. It is due to an accumulation of fluid and gas in the stomach and may be associated with severe dehydration, hypochloremia, oliguria, and vascular collapse. Death may ensue if appropriate treatment is not promptly instituted. It may occur following major or minor operations, injury, childbirth, and during chronic illnesses. The operation or injury may seem too inconsequential to cause this complication. These two cases are rather typical of this condition.

Case 1.: B. J. was a 20-year old colored male admitted to the Medical College Hospital on April 13, 1959 with second and third degree burns involving 50% of the body surface. On the second day of hospitalization, he complained of abdominal pain in the epigastric region. This progressed in severity during the following 24 hours. When examined for this progressive pain, the patient was extremely uncomfortable and required narcotics every three hours for relief. Exquisite epigastric tenderness was present. The upper part of the abdomen was moderately distended and markedly tympanic. The lower part of the abdomen was soft and non-tender. A diagnosis of acute gastric dilatation was made. No abdominal x-ray film was taken. A nasogastric tube was in place but was obviously not functioning. This was manipulated into the stomach and irrigated. A large quantity of gas and fluid escaped spontaneously. The patient experienced immediate relief and went to sleep.



Case 2. Marked distention of the stomach with gas several hours following operative reduction of fractures.

Case 2.: E. D. was a 6-year old child admitted to the Medical College Hospital on May 7, 1958 soon after being struck by an automobile. He sustained a compound fracture of the right tibia and fibula and a simple fracture of the right femur. Soon after admission, the wound was debrided, the fractures were

reduced and the patient was placed in balanced traction. Six hours following completion of this procedure, he complained of intermittent abdominal pain. The abdomen was moderately distended and tympanitic especially in the upper quadrants. The distention progressively increased during the next four hours. Roentgenograms of the abdomen revealed marked gastric dilatation and a moderate amount of gas in the small bowel. No free air was demonstrated in the peritoneal cavity. (Figure 1) Vital signs were within normal limits. A gastric tube was inserted and was effective in immediately decompressing the stomach and relieving the abdominal pain.

Discussion

It is most important to think about acute gastric dilatation when confronted with a patient in the early postoperative period who is in a grave condition. The slight cyanosis, dyspnea, rapid pulse, cold extremities, and profuse diaphoresis that some of these patients exhibit will often mimic the clinical picture of hemorrhage, embolism, or coronary occlusion. This complication usually occurs during the first or second postoperative day and is accompanied by vomiting of small amounts, nausea, pain, and abdominal distention in the upper quadrants. Muscle spasm and fever may be absent. The lower abdominal quadrants are often soft and flat. The pulse rate is elevated and when severe, the blood pressure is unstable. Percussion over the upper part of the abdomen elicits tympanitic notes unless the stomach is filled with fluid. A succussion splash can often be heard. Such conditions as high small gut obstruction, peritonitis, adynamic ileus, and persistent postanesthetic vomiting

must be differentiated from acute gastric dilatation. An abdominal roentgenogram both in the supine and upright position will be helpful.

Passage of a naso-gastric tube produces dramatic results. There is an explosive release of gas and fluid as soon as the tube enters the stomach. Naso-gastric tubes are used more frequently prophylactically for postoperative patients in present day surgery but must be properly in place and unobstructed to obviate gastric dilatation. If a tube is already in place its position and patency must be ascertained.

Massive quantities of fluid can accumulate in the stomach and because of the high chloride content, can result in severe dehydration and hypochloremic alkalosis. Hypokalemia can also be severe and is particularly noticeable when fluid losses are replaced. Appropriate electrolyte solutions containing a high content of chloride, adequate amounts of potassium, and smaller amounts of sodium should be utilized to restore circulation. A gastrorrhea may continue for two to five days and this loss must be balanced in therapy. Feeding is begun when gastric motility returns.

In summary, this complication is preventable with the use of a properly functioning naso-gastric tube in the early postoperative period. The diagnosis of acute gastric dilatation must always be considered when one is confronted with a patient in a grave condition several days following operation or trauma. Immediate gastric decompression and replacement of fluid and electrolyte losses will produce dramatic results. Failure of recognition and delay in treatment may result in death.

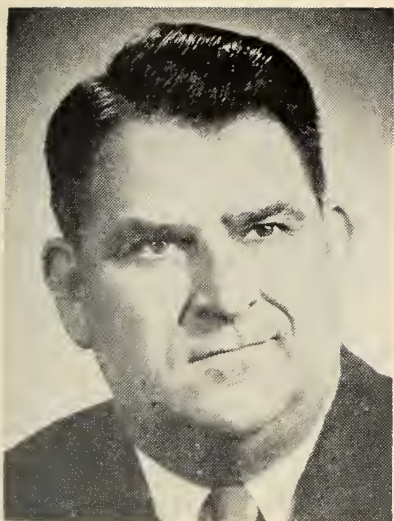
Acute appendicitis with perforation, R. R. Bradham, F. E. Kredel, and J. F. Green. (Charleston) J.A.M.A. 173: 1342-1344, July 23, 1960.

A series of 98 patients who had acute appendicitis with perforation treated on the wards of the Roper Hospital from January, 1950 to January, 1959 are analyzed from the standpoint of diagnosis and treatment. Pain in the abdomen and tenderness in the right lower quadrant occurred in 97 patients. Nausea occurred in 82 cases and vomiting in 77. Constipation and diarrhea were infrequent symptoms. Eighty-nine patients had fever, an elevated pulse rate, and an elevated leukocyte count. The duration of symptoms was not informative. The most effective means of treatment based on the results in these cases is given. Four patients died and are discussed briefly. Two were in the operative and two were in the non-operative group. Several factors to be anticipated in non-operative treatment were brought out in this study. The rationale of the operative and non-operative management of acute appendicitis with perforation are discussed.

A comparison of the incidence of bacteriuria among hypertensives and matched controls by C. M. Smythe, M. D., C. F. Rivers, M. D., and R. M. Rosemond, M. D. (Charleston) A.M.A. Arch. Int. Med. 105: 899, June 1960.

Thirteen (18%) of 77 previously unstudied hypertensives were found to have unsuspected bacteriuria. Six (8%) of the controlled group matched for age, sex, race, and incidence of diabetes were found to have unsuspected bacteriuria. By the X^2 method this difference is not significant statistically despite its obvious clinical implications. Clean-voided urines which have been collected by women and coupled with quantitative urinary bacteriology are valuable in screening for urinary tract infections, but a single high count cannot be accepted as diagnostic of significant urinary tract infection by this method.

The high incidence of urinary tract infection makes urine culture and urologic investigations mandatory in the survey of persons with hypertension, especially women. The absence of white cells in the urine does not reliably exclude urinary tract infection.



President's Pages

REMARKS TO THE STUDENT BODY OF THE MEDICAL COLLEGE OF SOUTH CAROLINA OPENING DAY—SEPTEMBER 9, 1960

One of the emoluments that goes with the office of President of the South Carolina Medical Association is the privilege of addressing the Student Body of the Medical College of South Carolina. It is an honor to be here to address this group, during your opening convocation.

Much of what I have to say will be in general terms and will be applicable to all of you. Some of what I have to say will be specially directed to Medical Students.

I wonder if you realize that you are the "cream of the crop"? Each and every one of you was chosen out of many applicants because of your superior scholarship ability, and aptitude.

Why are you here? Why did you decide to take up Nursing, Pharmacy, or Medicine?

Your interest in the subject may have been stimulated by many reasons. You might have come from a family of nurses, pharmacists, or physicians. Some close friend or associate in the professions may have persuaded you. Some experience in your life may have given you desire to study the Healing Arts. Whatever the background, basically you have decided to become professional men and women for two fundamental reasons: (1) The desire to be of service to mankind, and (2) the desire to make a comfortable livelihood.

Since you are the "cream of the crop", and are now studying at one of our country's finest medical institutions, it would also be good to think of not only *why* you are here but, also, *how* you happened to be here.

Most of you have had to study hard in High School and College in order to have the scholastic record necessary for your admission to this institution. Many of you have had financial hardships along the way, and may still be "pinched" at times. Some have no financial worries. Some of you are married. The question of *how* you happened to be here is not an easy one to answer. The events which have blended together during your life, and culminated in your reaching this plateau of development may be many and complex; however, one thing is certain—you did not get here without the help of others. None of us is self-made. Indeed, there is no such thing.

I would like all of us here, students and graduates alike to think back to the people who have helped motivate our lives.

First the parents, guardians, or others responsible for our proper bringing up. Some have not been able to give all the financial help which they would like to have given, but the lessons of honesty, diligence, respect, and civic responsibility invested in us by them was much more valuable. Remember also the desire to learn stimulated in us by our teachers in elementary and high school; the athletic coach, whose aim was to see that we learned to give and take, and to play the game square and always obey the rules; our scout master, who taught us to be part of the team; that good buddy, or inspiring instructor or the chance meeting with a stranger which may have stimulated our desire to serve.

Our Sunday school teacher and our pastor, instilled in us love of our fellow man, and our steadfast and unalterable belief in a merciful and almighty God, whose wonders we are privileged to witness daily as we delve into the innermost secrets of life in our laboratories and on our medical and surgical wards. Indeed, the miracle of healing, daily witnessed by us, would give faith to the most ardent non-believer.

Any, or all, of these people here described may have been responsible for your being here. But they are not all.

I wonder how many of you realize your obligation to the tax payers of the State of South Carolina? In addition to the money you yourselves have paid for tuition, board, room, books, and laboratory fees, etc., the State of South Carolina has contributed in addition a very substantial amount. For each of you who has gone through the public schools of the State and

who attended one of our State colleges, South Carolina will have contributed an additional 40 to 50 thousand dollars by the time you have received your medical diploma. For those of you studying nursing and pharmacy the amount is proportionately smaller but still substantial. In addition to this, many of your instructors serve without pay and are glad to help pass on to you whatever knowledge they possess in the healing arts.

Professional classes must be limited because of the lack of sufficient laboratory and teaching facilities to insure adequate and thorough training for all who apply. This is absolutely necessary so that the public welfare will not be jeopardized by the graduation of unqualified people. Because classes are limited, and you were chosen, also means that some other person had to be turned down. This person's desire to serve may be just as great as your own, and many times he feels that he was unfairly treated in not being admitted. But, since it is you that has been afforded the opportunity, it is incumbent on you to make the most of it.

Now you may see what I am up to. I am putting you on the spot. Because of all these things that have been mentioned here, you have certain obligations and responsibilities. You are expected to be persevering, diligent, and attentive and conscientious in your attitude toward both your practical and theoretical work. Nothing else will suffice.

As you pursue your studies through the years, I would admonish you to develop a sense of tolerance, of duty, and responsibility to your fellowman. You are being educated for a life of service, of service to people to whom you already owe much. Learn your theory well, and apply yourself diligently to the practical work that is made available to you in the labs and on the wards.

It is easy to fall into the habit of considering your patient as "that old man in room 206", or as "guinea pigs", so to speak, for your experimentation. I implore you not to fall into this habit. Realize that all patients are human beings, with the same hopes and fears that we ourselves know. They should never be considered just as a number, or their care as a burdensome chore; but as individuals whose illness it is our privilege to study and try to understand, and who must be accorded all the dignity and care that it is possible for us to give.

When you graduate and get into private practice, your success is going to depend in large part on your ability to instill confidence and get along well in your relationship with your patients and fellow practitioners. I would ask each of you to review regularly the Florence Nightingale Pledge, the Pharmaceutical Code, or the Hippocratic Oath; and as you move forward from year to year, be sure that you are keeping up with the spirit of these pledges as well as your scholastic averages.

I would caution you against arrogance. It is easy to criticize the referring physician, or the patient's family doctor who is not in a position to have all of the laboratory tests and x-rays that are part of the daily routine in a teaching hospital. Do not sell the "local M. D." short. What he lacks in laboratory facilities he must of necessity make up in basic medical knowledge, logic and common sense. It has been said that an internist being trained nowadays must have at least a hundred dollars worth of lab tests and x-rays before he can even venture an opinion. Mind you, I did not say that this was bad; I didn't say it was good either. Also I want to quote from Dr. Max Thorek, of Chicago, who was one of the greatest surgical teachers I have ever known, who described a type that we all have known at one time or another:

"The haughty young surgeon reminds me of nothing so much as a monkey, in that the higher he climbs, the more he shows the most unattractive part of his anatomy."

I would also caution you about developing an attitude that, when you graduate you will charge all that the traffic will bear. It is a great temptation for a young professional man, burdened by debt and self sacrifice during his training years, not to let his enthusiasm for high fees over run his good judgement. Much criticism is directed against our profession by overcharging. Insurance companies are forced to raise premiums and cancel policies because their benefits have been over-utilized. This temporary monetary advantage blends into insignificance if, because of it, we create a climate of intolerance toward medical fees, and drive our nation into socialized medicine. I say "drive it" to socialized medicine, because I am confident that at the present time most people do not want socialized medicine, and if it comes at all, it will be the result of our own greediness.

At the present time, I have on file several protests from insurance companies against fees charged by physicians, which they feel are too high. I will give one example: an automobile injury—simple fracture of a metacarpal—in the hand—not the wrist—and multiple contusions and abrasions; also, an inguinal hernia. The surgeon who repaired the inguinal hernia charged \$125.00. 5 weeks hospitalization ran \$475.00. The doctor who originally attended the

man and treated the fracture, taking care of him in the hospital, charged over \$1400.00, just about all that was left of a \$2,000 medical coverage. This \$1400.00 charge may be justified. However, the insurance company has challenged it, and correctly so. Its payment awaits further proof.

Do not try to make it all at once, give service. Let people be proud to speak of you as their family doctor, and your remuneration will come not only in pleasure and enjoyment in your work, but in bountiful financial rewards without having to charge excessive fees.

It is said that Hippocrates was the embodiment of all that a physician should be. He was a close observer, a humane scholar, and a man filled with a desire to help his patients and to insure that by his teachings and experience others would benefit. His high ideals as set forth in the "Hippocratic Oath" have been respected by physicians and surgeons for two thousand years.

In addition, I would leave this one final thought: The ethics of the Healing Arts, pharmacy, nursing, and medicine, are the same as life itself and was simply stated many years ago, never to have been improved upon: "Do unto others as you would have them do unto you."

Joseph P. Cain, Jr., M. D.

Editorials

FOUNDERS DAY NEXT MONTH

Founders Day at the Medical College will be here again on November 17, and the College offers an attractive program of up-to-the-minute material. The programs have varied considerably in content from year to year and this is a new sort of offering which should appeal to the Alumni and other guests of the college.

Founders Day offers all interested doctors an opportunity to observe the development in the Medical School and to make closer contact with members of the faculty.

In the past the Alumni in the stricter sense and the interested physicians of the state have been good patrons of this program. The approaching meeting offers an excellent variety of scientific material and local entertainment. A large attendance may be expected.

NURSING EDUCATION

A recent lengthy statement of the National League for Nursing seems to give more recognition and concession to the obvious fact that service in nursing is as important as a higher education. While there is no indication that the League has abandoned any of its high ideals for the pursuit of the type of education which will make the teacher or administrator

in nursing, the report seems to give more concern to what most concerns the average doctor, which is the supply of the run-of-the-mill bedside nurses who are so essential to effecting his treatments. The report gives a review of various fields and opportunities in the study of nursing and covers very well the current situation in the field. It seemed to the writer to be more practical and rational than some reports which have come from the League and it should clarify matters for the uninformed.

This is a good step. Another good step which nurses in general might take would be to express their opposition to the various schemes for the socialization of medicine such as the one typified by the Forand bill.

VETERANS HOSPITAL

A short time ago news came down from Washington that the Veterans Administration was contemplating building another hospital in the state and that Charleston would be the likely site for it. This word was received immediately with applause and enthusiasm by the legislative representatives of the state and with similar enthusiasm by the authorities of the Medical College of South Carolina. The former saw material benefit to the state in the proposed new hospital, and the latter saw

benefits for teaching and for interlocking relations between the Medical College and the new hospital.

At the time this is written there is an obvious hassle in the South Carolina House Delegation over the question of location of the new hospital. Because of the limitation of the number of beds assigned to the state, the construction of a large new 500-bed hospital at Charleston would possibly result in a depletion of the Veterans Hospital in Columbia, perhaps to the extent of 300 beds. The obvious and natural political course of the Representatives from the western and mid-state districts is to oppose any move which would decrease the activity in Columbia and perhaps force veterans from those parts of the state to go to Columbia because of reduction in capacity in the present hospital. The obvious and natural course of the Representatives from the lower part of the state is to urge that Charleston be the site. Proximity to the Medical School has been advanced as an important feature of construction there.

In a discussion of this matter in the press, nowhere has there seemed to appear any word concerning the well recognized fact that Veterans hospitals in general have been perhaps too numerous and additions are not desirable, since each implies a little more and more of government medical activity. A statement backed by apparently reputable statistics that there is a tremendous amount of abuse of the privilege of using these hospitals by veterans who can not show that their current troubles are in any way related to their previous service. It has been advocated in many quarters that some of the present Veterans Hospitals be closed, or that some other use be made of them. It might be wondered whether in the enthusiasm of local concern the broader picture of the activities of the Veterans Administration has not been disregarded.

NATION FIGHTS NOVOTEITIS*

Prominent leaders in American medicine have again warned all America against a possible epidemic of Novoteitis, a disease affecting many adult Americans. These same leaders point out that although vast sums have been spent on research and education since the last

great outbreak in 1956, there is always a possibility of a flare-up. Because of the nature of this peculiarly American disease (of which too little is known), it can appear in many areas of the land at the same time. Although of short duration, the epidemic often leaves the nation with serious after affects.

Researchers have found, however, that immunity from novoteitis is obtained through constant vigilance. They have also determined that the disease attacks both males and females beginning at the 21-year level, although one state reported cases among 18 year olds.

During the past four years, the study showed that novoteitis is no respecter of personalities, as it strikes at all levels of the nation's income groups. However, the facts show that a large number of cases occur among members of the professions, with doctors of medicine being among those often afflicted.

Temporary paralysis of the hand and loss of forward motion in the feet, both characterize the disease. Strangely enough, the diagnoses have been more readily made by political observers than by busy men of American medicine.

The implications of the above allegory are many. To the practicing profession, it is both a challenge and an indictment. To the medical student it can mean just one thing—the development and use of the strongest antibiotic known to politics—the individual doctor's vote.

Only when physicians-to-be and physicians-who-are accept their full and complete responsibilities of American citizenship, can there be hope of relief from the ravages of novoteitis—a disease welcomed by self-perpetuating politicians to the detriment of the people at large. —RFS.

*No-vote-itis

COLUMBIA ACTS

Members of the Columbia Medical Society have received a letter headed "Richland County Republican Clubs and Citizens for Nixon-Lodge" and signed by several of its members who are interested in the promotion of a campaign for the election of the candidates named. This effort is further evidence of

the revolt against the undesirable platform of the Democratic party and a blow for the obstruction of the portions which aim frankly at the socialization of medicine.

While this is not an official stand by the Medical Society, anyone present at its September meeting would have been impressed by the number of buttons being worn as evidence of support of these candidates, and by the enthusiasm with which a number of the members present were promoting further conversion to the cause. It seems to be a healthy sign that doctors are taking more active and a personal interest in political affairs. Their influence could be very strong in swinging a vote.

DENTIFRICES AND DECAY

It is not often that an official medical or dental society offers endorsement of special commercial products, other than to discuss

their merits from a strictly scientific evaluation. Perhaps this is what the action of the American Dental Association amounts to since it has recognized Crest toothpaste as the first and only effective dentifrice which works against tooth decay. The Dental Association is careful to point out that while the effect of the stannous flouride which the preparation contains assures active assistance in the fight against the process of decay, that the use of this particular toothpaste is a worthwhile help, but by no means a cure-all in the effort to reduce caries. The Association recognizes that the use of: "(1) dietary fluorides, best provided by fluoridation of community water supplies; (2) topical application of fluoride solutions directly to children's teeth by the dentist, and (3) the stannous fluoride dentifrice" are effective in the order listed. From the standpoint of cost, effectiveness and convenience, fluoridation is by far the most desirable method, according to the Council.



PROGRAM FOR FOUNDERS' DAY

THURSDAY, NOVEMBER 17

MORNING SESSION

Presiding, Dr. William O. Whetsell, Pres., Alumni Assoc. of Medical College of South Carolina

8:30 A. M.—Registration — Greetings—Dr. John T. Cuttino

9:15 A. M.—Sickle-Cell Disease—Dr. Paul V. Woolley

9:45 A. M.—Office Procedures in Ophthalmology for the Family Physician—Dr. W. W. Vallotton

10:05 A. M.—Evaluation of the Hypertensive Patient—Dr. John A. Spittel, Jr.

10:35 A. M.—COFFEE BREAK

10:55 A. M.—Diagnosis of the Anemias—Dr. Richard W. Vilter

11:25 A. M.—Dysmenorrhea—Dr. Martin L. Stone

11:55 A. M.—The Office Diagnosis of Cancer—Dr. John C. Hawk

12:15 P. M.—Question period.

12:45 P. M.—ALUMNI LUNCHEON

AFTERNOON SESSION

2:00-5:00 P. M.—Clinics. Conducted tour of Clinics with presentation and informal discussion of interesting cases.

ANNUAL BANQUET, Alumni Association and Guests

7:30 P. M.—Francis Marion Hotel

Refreshments

Dinner. Presiding, Dr. John T. Cuttino, Acting President, Medical College of South Carolina

"Vignette of a Founder—Samuel Henry Dickson", Dr. J. I. Waring

"Medicine and Mankind"—Dr. Frederick A. Collier

FRIDAY, NOVEMBER 18

MORNING SESSION

Presiding, Dr. Martin M. Teague, President, S. C. Academy of General Practice

9:00 A. M.—Management of Insect Sting Hypersensitivity—Dr. Kelly T. McKee

9:30 A. M.—Values and Limitations of Routine Cranial Transillumination—Dr. Paul V. Woolley

10:00 A. M.—Thrombosis and Embolism—Recognition and Management—Dr. Frederick A. Collier

10:30 A. M.—COFFEE BREAK

10:50 A. M.—Postoperative Complications—Dr. Randolph Bradham

11:15 A. M.—The Medical Treatment of Essential Hypertension—Dr. John A. Spittel, Jr.

11:45 A. M.—Question Period

12:00 Noon—Clinical Pathological Conference—Dr. H. Rawling Pratt-Thomas

1:00 P. M.—LUNCH

AFTERNOON SESSION

Presiding, Dr. Dale Groom, Ass't. Professor of Medicine, Medical College of South Carolina

2:00 P. M.—Migraine—Diagnostic and Therapeutic Considerations—Dr. Neil Marshall

2:30 P. M.—Treatment of the Anemias—Dr. Richard W. Vilter

3:00 P. M.—Acceleration and Induction of Labor—Dr. Martin L. Stone

3:30 P. M.—COFFEE BREAK

3:45 P. M.—Office Diagnostic Procedures in Renal Disease—Dr. Cheves M. Smythe

4:05 P. M.—Question Period

4:20 P. M.—Symposium on Automobile Accidents

Dr. Frederick Kredel, Moderator Dr. Kenneth Lynch, Jr.

Dr. John Arthur Siegling Dr. Gordon T. Wannamaker

Dr. O. Rhett Talbert Mr. Coming B. Gibbs, Attorney-at-Law

FACULTY

GUEST SPEAKERS

Richard W. Vilter, M. D.; Professor of Medicine, Univ. of Cincinnati College of Medicine; President, American Society for Clinical Nutrition.

Frederick A. Collier, M. D.; Professor, Emeritus, of Surgery, Univ. of Michigan; Fellow, Royal College of Surgeons (Edinburgh and England); Past President of American College of Surgeons and of American Surgical Society.

John A. Spittel, Jr., M. D.; Consultant in Internal Medicine, Mayo Clinic and Instructor in Medicine, Mayo Foundation.

Martin L. Stone, M. D.; Professor of Obstetrics and Gynecology; New York Medical College.

Paul V. Woolley, M. D.; Professor of Pediatrics; Wayne Univ. Medical School.

SPEAKERS FROM FACULTY OF MEDICAL COLLEGE OF S. C.

Randolph R. Bradham, M. C., Asst. Prof. of Surgery

John C. Hawk, M. C., Associate Professor of Surgery

Frederick E. Kredel, M. D., Prof. of Surgery

Kenneth M. Lynch, Jr., Professor of Urology

Neil Marshall, M. D., Associate in Neurology

Kelly T. McKee, M. D., Associate Prof. of Medicine

H. Rawling Pratt-Thomas, M. D., Prof. of Pathology and Dean, School of Medicine

John A. Siegling, M. D., Clinical Professor of Orthopedic Surgery

Cheves McC. Smythe, M. D., Asst. Prof. of Medicine

O. Rhett Talbert, M. D., Asst. Prof. of Neurology

W. W. Vallotton, M. D., Assoc. Prof. of Ophthalmology

Gordon T. Wannamaker, M. D., Asst. Prof. of Medicine

FOUNDERS' DAY — 1960

Founders' Day at the Medical College of South Carolina has traditionally become a sort of combination homecoming and post-graduate course for our Alumni and practicing physicians of the state. As such, it serves a dual purpose, social and professional. Plans this year are for considerable expansion of Founders' Day activities with the hope that many physicians who have not visited their alma mater in recent years will avail themselves of this invitation to be the guests of the College November 17th and 18th.

A streamlined and fast moving scientific program of wide general interest has been arranged, to be presented by five distinguished out-of-state speakers supported by a dozen members of the Medical College Faculty. Subjects range from anemia to acceleration of

labor to evaluation and medical treatment of hypertension to migraine and post-operative complications. There will be a clinical-pathological conference with the guests themselves as the participants, and one afternoon will be devoted to presentation of interesting cases in special clinics throughout the hospitals where the patients can be examined individually and discussed freely. Emphasis throughout will be on recent developments in the medical fields, particularly those applicable to every day practice. On Thursday is the Alumni Luncheon and that evening the annual banquet for members and their wives. The program closes Friday evening with a symposium on a subject of increasing importance in medicine—automobile accidents.

So mark your calendar now and plan to be in Charleston for the 1960 Founders' Day.

NO COMMENT DEPARTMENT

KENNEDY:

'Unfortunately, voluntary health insurance has not and cannot do the job. Although insurance companies have made a mighty effort . . . it is unlikely they can reach our older citizens.'

NIXON:

'I have consistently opposed and will continue to oppose any compulsory health insurance program. The answer to the problem is voluntary co-operation rather than compulsory regimentation.'

THE MEDICAL ASSOCIATION OF GEORGIA

IS PROMOTING THE USE OF THIS PLACARD BY ALL DOCTORS

THIS OFFICE WILL BE CLOSED ON ELECTION DAY

NOVEMBER 8, 1960

DURING THE HOURS _____ TO _____

SO THAT OUR EMPLOYEES AND PATIENTS MAY VOTE

YOUR VOTE IS ESSENTIAL IN OUR DEMOCRACY

M.D.



Seated at the conference table of the staff of Womack Army Hospital are clockwise: Colonel James G. Shaw, Commanding Officer of the 446th General Hospital with sections in Columbia, Charleston and Greenville, S. C.; Lieutenant Colonel I. Ripon LaRoche, Deputy Commanding Officer of the 446th, from Camden; Second Lieutenant Earl D. Short, Jr., Florence, Second Lieutenant Ervin E. Bagwell, Johnston, First Lieutenant Joseph Lee, III, Landrum, all of whom are medical students at the Medical College of S. C.; Captain Paul W. Peeples, physician from Creer; Captain Richard G. Price, physician from Charleston; Captain Howard W. Higgins, dentist from Spartanburg; Second Lieutenant Heyward Hudson, Walterboro, and Second Lieutenant David R. Beckham, Winnsboro, both of whom are medical students; Colonel Charles A. Yeargin, a physician and Commanding Officer of Section II of the 446th in Greenville, and Colonel Byron A. Stegar, Commanding Officer of Womack Army Hospital, Fort Bragg, N. C. who was the host to the 446th. Standing from left to right are medical students, First Lieutenant Lawrence C. Freeman, Jr., Greenville; Second Lieutenant Charles W. Derrick, Marion; Second Lieutenant John J. Britton, Sumter; Second Lieutenant Laurie N. Ervin, Dillon, and Second Lieutenant George H. Nutt, Clemson. The medical students are among the first to participate in the early commissioning program which the 446th pioneered in just two years ago.

MEDICAL RESERVISTS PRAISED FOR HIGH DEGREE OF READINESS AND PIONEER ROLE WITH MEDICAL STUDENTS...

The 446th General Hospital Reserves with headquarters in Columbia, S. C., just completed at Fort Bragg, N. C. one of the most beneficial encampments of its twelve year training history, according to Colonel James G. Shaw, Commanding Officer and a practicing physician in civilian life.

"Furthermore," said Colonel Shaw, "I'm happy to report that competent authorities have stated the 446th General Hospital is the most mobilization-ready medical unit in Third Army. We not only have highly skilled personnel in such professional sections as Medicine and Surgery, Nursing, Laboratory, X-Ray, etc. but such supportive elements as administration, supply, and transportation have a highly dependable

nucleus on which to build if called to active duty."

Being the largest (1000 bed) and most diversified of reserve medical units at present at Bragg, the 446th has worked side by side with its active army counterparts at the modern Womack Army Hospital. "The teaching facilities of Womack have been excellent", said Colonel Shaw, "and I'm sure our student personnel in the draft age group will carry an enthusiastic story back to their classmates about the advantage of the Reserve program."

Though not usually engaged in Modern Army Concepts at present, the 446th personnel have taken advantage of several opportunities for familiarization and training in this area. The helicopter, now a standard vehicle of the "Army of the Future", was utilized to acquaint doctors, nurses and medical service personnel with new techniques for medical evacuation. The 82nd Airborne gave ample evidence of the extreme readiness needed for our retaliatory

forces in quick "brush fire" wars or sneak nuclear attacks when our armed services would have only the slimmest of opportunities to strike back. In a matter of minutes after orders were given and with clockwork precision, masses of human war machines and their supportive equipment billowed out of troop carrier planes and helicopters in demonstrations that left the medics with a lasting impression of awe and respect.

The reservists were shown lightweight nylon tentage and portable aluminum hospital equipment which will make air drops of vital field hospitals highly practicable. Fast, mobile combat and supportive equipment were demonstrated for familiarization.

The 446th strutted a little itself in demonstrating its high degree of readiness in all phases of professional and nonprofessional operations. Discussing the mission of the 446th, Lieutenant Colonel I. Ripon LaRoche, Deputy Commanding Officer and practicing physician in Camden, S. C. said, "We are in an advanced stage of training, not a basic one. As such we would form the cadre to which additional personnel would be assigned for the care and specialized treatment of 1000 patients in the communications zone. We are already performing part of this function in our cadre of 18 medical students from the Medical College of South Carolina who are learning medical knowledge and administrative techniques unique with the army. This assures them of immediate command of the administrative and professional knowledge that was so hard earned by doctors of World War II and also keeps the interest of the reserve at a high point."

The Commanding Officer of Womack Army Hospital, Colonel Byron A. Steger, was impressed by the spirit of cooperativeness and competence in the unit which, during their stay, were superimposed on the different departments of Womack. Of particular noteworthy, he said, was "... their pioneer role in the early commissioning program for medical students." The 446th under the command of Colonel Shaw, and such interested parties as Brigadier General James H. Kidder, Special Assistant to the Surgeon General's Office and Major General Frank S. Bowen, former Commanding General, XII Corps, Atlanta, paved the way for recognizing the importance of training medical reservists in such progressive ways to meet changing conditions.

Colonel Steger commented appropriately, "We in the Regular Army are cognizant of the Reserve Unit's potential in the event of future war. Only the combined efforts of the Regular Army, Reserve Army and the National Guard make it possible to have an efficient military organization—One Army—which can be depended on."

After 15 days the nearly 200 officers and men of the 446th return to their citizen-soldier status in their hometowns in and around Columbia, Greenville and Charleston, S. C. to train weekly until next summer's opportunity for "Full Dress Rehearsal" as a proud part of America's "Deterrent to War".

NEWS

20 PHYSICIANS LICENSED FOR SOUTH CAROLINA PRACTICE

The State Board of Medical Examiners of South Carolina held a meeting recently in Columbia to interview applicants for endorsement. Twenty physicians were licensed to practice in South Carolina. They are as follows:

Dr. Charles I. Allen is a 1951 graduate of Bowman Gray School of Medicine. He has completed a residency in surgery in West Virginia and is now in practice in Laurens.

Dr. Albert W. Bailey graduated from the Medical College of Georgia in 1949. Dr. Bailey is a pathologist and served on the staff at the Medical College of Georgia before moving to Greenwood where he will be at Self Memorial Hospital.

Dr. Ann A. Bailey is a 1949 graduate of the Medical College of Georgia and is trained in pediatrics. She practiced in Gracewood, Georgia before coming to Greenwood.

Dr. William P. Bennett graduated from the Medical College of Virginia in 1956; served his internship in Baltimore; and is presently taking a residency in obstetrics and gynecology at the Columbia Hospital.

Dr. Aaron W. Brown, a graduate of the Medical College of Virginia in 1930, took a residency in radiology. He has practiced in Pennsylvania, West Virginia, Virginia and Georgia. He was located in Shelby, North Carolina before moving to Hartsville.

Dr. Roger W. Cole graduated from the University of Maryland School of Medicine in 1955. He served a residency in ophthalmology at Johns Hopkins and is now practicing in Columbia.

Dr. Griggs C. Dickson, a graduate of the University of North Carolina School of Medicine in 1955, has completed a residency in pediatrics at North Carolina Memorial Hospital. He is now located in Hartsville.

Dr. Daniel J. Enger, a 1954 graduate of the St. Louis University School of Medicine, took a residency in orthopaedics. He is now in service at the U. S. Naval Hospital in Beaufort.

Dr. Austin T. Hyde, Jr. graduated from the University of Virginia School of Medicine in 1951. He served a residency in medicine at Duke and now practices in Rutherfordton, N. C. He will be in Spartanburg once a week for consultation in allergy.

Dr. William D. Irvine, a 1951 graduate of the Medical College of Virginia, took a residency in internal medicine in West Virginia and is now located in Laurens.

Dr. Joseph L. Kurtzman graduated from N. Y. University College of Medicine in 1950. He took a residence in ophthalmology. He was recently discharged from the Navy and is now located in Charleston.

Dr. Emmett M. Luncford, Jr., graduated from the

University of Tennessee Medical School in 1953. He served his internship and a residency in orthopedics at Columbia Hospital. He is now practicing at the Moore Clinic in Columbia.

Dr. John C. Matthews, a graduate of the Medical College of Georgia in 1957, is licensed in Georgia. After serving three years in the Army he is now in General Practice in Graniteville.

Dr. Charles H. Owens, a 1954 graduate of the University of North Carolina School of Medicine, took a residency in Ob-Gyn. and is now in practice in Hartsville.

Dr. James C. Parker, Jr. is a 1954 graduate of the University of North Carolina School of Medicine. He took a two year residency in pediatrics and is now located in Hartsville.

Dr. Henry J. Ritchie graduated from the University of North Carolina School of Medicine in 1957. He took his internship at the Teaching Hospitals of the Medical College of South Carolina and is now in general practice in Charleston.

Dr. Calvin T. Smith graduated from Bowman Gray School of Medicine in 1955. He took a residency in urology and is now located in Greenville.

Dr. Norman Solod graduated from the Medical College of Virginia in 1939. He took a two year residency in internal medicine. He is presently at the Veterans Hospital in Columbia.

Dr. Claude B. White, a 1936 graduate of the Medical College of Virginia, has been in service for twenty-three years. He took a residency in dermatology. He will practice in Greenville.

Dr. Edward S. Williams, Jr. graduated from the University of North Carolina School of Medicine in 1954. He has completed a three year residency in medicine at North Carolina Memorial Hospital and is now practicing in Hartsville.

Carium Joseph, M. D. announces the opening of his practice in Charleston, S. C. Practice limited to Obstetrics and Gynecology.

CHARLESTON RANKS HIGH IN CORONARIES

Savannah, Ga. and Charleston, S. C. rank first and second among all the metropolitan areas of the nation in death by coronary heart disease, but danger of death from the disease is not nearly so severe in Florida, or in inland areas of South Carolina and Georgia.

This is indicated in a study made of coronary heart disease, the leading cause of death in this country, by Dr. Philip E. Enterline, Dr. Arthur E. Rikli, Herbert I. Sauer and Merton Hyman of the U. S. Public Health Service.

Among 163 metropolitan areas identified in their study, death rates for coronary disease varied from 299 per hundred thousand in Lincoln, Nebraska, to 826.8 in Savannah, Ga.

In Charleston, S. C., the rate was found to be 825.6,

to rank the city second among metropolitan centers in heart deaths.

The rates are for each 100,000 white men in the age-group 45 to 64, those most prone to heart attacks.

High death rates were found in a strip near the South Atlantic Coast, stretching from Delaware to Central Georgia, the specialists reported.

Columbia, South Carolina, ranked 48th, with 602.2 deaths per hundred thousand, but Greenville in the same state, had a ratio of 692.2, ranking that city 14th in coronary deaths.

SOUTH CAROLINA TRAILS WITH NUMBER OF DOCTORS

South Carolina trails a sixteen-state southern area in the number of physicians for every 100,000 persons, according to figures released by the Southern Regional Education Board of Atlanta, Georgia.

In 1959, the sixteen state area—South Carolina, Georgia, Florida, Texas, North Carolina, Maryland, Virginia, Tennessee, Louisiana, Kentucky, Alabama, Oklahoma, Mississippi, West Virginia, Arkansas and Delaware—had 53,957 non-federal doctors, or 100.5 physicians, including retired physicians, for every 100,000 persons, a figure considerably below the national ratio of 128.6.

South Carolina, in 1959, had 1,877 doctors for a ratio of 77.7 doctors per 100,000 persons—ranking the state twelfth in the area for number of doctors and sixteenth for number of doctors per 100,000 persons.

Historically, the South has been the area most poorly supplied with doctors. Yet since 1949, the region's supply of physicians in proportion to population has been increasing slightly in contrast to the national picture.

DR. SANDIFER OPENS OFFICE

Dr. Peter B. Sandifer has announced the opening of his office at 2005 Hampton Street, Columbia, for the practice of Urology.

Dr. Sandifer received his premedical education at the Citadel and the University of South Carolina. He attended the Medical College of South Carolina, graduating in 1955, where he was a member of Phi Rho Sigma Medical Fraternity.

His internship and three years of residency training were completed at the Medical College of South Carolina Teaching Hospitals. During the past year Dr. Sandifer has been serving as chief resident in Urology at Grady Memorial Hospital and as a teaching fellow for Emory University School of Medicine at Atlanta, Georgia.

6 FIELD HOSPITALS ALLOTTED TO STATE

The Office of Civil and Defense Mobilization of Battle Creek, Mich., has approved six additional emergency hospitals for South Carolina, it is announced by C. B. Culbertson, director, S. C. Civil Defense Agency.

Those cities to receive the hospitals this month are

Laurens, Newberry, Dillon, Sumter, Darlington and Bethune.

Nine hospital units are already positioned in Calhoun Falls, Rock Hill, Lancaster, Bennettsville, Moncks Corner, Winnsboro, St. George, Florence and Columbia, bringing the total number in the state to 15.

There is also a training hospital assigned to Greenville. By mid-September this hospital will be converted to a mobile unit designed to train medical personnel in those cities with emergency hospitals.

The value of these 200 - bed Civil Defense Emergency Hospitals (CDEH), according to Mr. Culbertson, is immeasurable. Many of the state's larger hospitals are located in or near metropolitan centers designed as likely enemy target areas. This means that if war should strike many of the regular hospitals would be destroyed or damaged beyond use. But the emergency hospitals, stored in protected location, could provide the medical facilities needed to care for many of the sick and injured.

The CDEH is a "packaged" hospital containing all the equipment essential for operating a 200-bed general hospital. Although items such as the X-ray unit, operating tables, cots and surgical instruments are plain in design, they are comparatively inexpensive, rugged and functional.

The present CDEH units are an adaptation of the mobile Army surgical hospital developed and tested during the Korean War. Continuing improvements have been added since 1952 and the CDEH has been converted to civilian rather than military needs. Supplies and equipment for the hospitals are maintained through continuous procurement programs and by rotation and replacement of certain supplies (drugs) as they become outdated.

SOCIAL SECURITY

Physicians will not be placed under social security this year.

The health care for the aged measure approved by Congress does not contain this provision. The original bill as it passed the original bill as it passed the House would have brought under social security for the first time self-employed physicians, and medical and dental interns. However, the Senate Finance Committee knocked the provision out and it was not reinstated.

A. M. A. News

INDIANA DOCTOR RETURNS HOME TO NATIVE GEORGETOWN

A native Georgetownian, who earned a real niche in the memories of his adopted Indiana home, has returned to live at home.

A veteran surgeon-diagnostician and civic leader in Evansville, Ind., Dr. William Ehrich is establishing his home in the Georgetown area where he was born January 11, 1881.

Dr. Ehrich contributed greatly to the growth of medical services in Evansville.

In Evansville, where he is known as one of the city's leading surgeons, a urological surgery in a new hospital wing is being dedicated in his honor.

Dr. Ehrich was chief of staff of Deaconess Hospital in Evansville for several years and established the hospital's first radiology department.

Two Charleston doctors will participate in the annual meeting of the Southern Medical Association in St. Louis October 31—November 3, 1960.

Dr. Cheves McC. Smythe, Department of Medicine, Medical College of South Carolina, will participate in a Pylonephritis Symposium to be held in conjunction with the meeting. Dr. Smythe, with other leading experts on diagnosis and treatment of pyelonephritis will participate in a round-table panel discussion moderated by Dr. George Schreiner, Associate Professor of Medicine, Georgetown University, Washington, D. C.

Dr. Clay W. Evatt of Charleston, S. C., will speak on "Congenital Cataracts" before the Section of Ophthalmology and Otolaryngology of the Southern Medical Association on October 31st.

DR. GARRISON OPENS OFFICE

Dr. Paul H. Garrison has opened an office in the Medical Arts Building, Greenwood, S. C., specializing in ear, nose, throat, and facial surgery.

Dr. Garrison is a native of Gaffney. A graduate of the Medical College of South Carolina, he interned at Spartanburg General Hospital. He was a general practitioner in Greenwood for a period of two years before leaving his practice for specialized study.

ANNOUNCEMENT OF REGULAR CORPS EXAMINATION FOR MEDICAL OFFICERS UNITED STATES PUBLIC HEALTH SERVICE COMMISSIONED CORPS

Competitive Examinations for appointment of physicians as Medical Officers in the Regular Corps of the United States Public Health Service Commissioned Corps will be held throughout the United States on January 31, and February 1 and 2, 1961.

Appointments provide opportunities for career service in clinical medicine, research, and preventive medicine-public health. They will be made in the PHS officer grades of Assistant Surgeon and Senior Assistant Surgeon, equivalent to Navy ranks of Lieutenant (j.g.) and Lieutenant, respectively.

FACILITIES URGED FOR RETARDED CHILDREN

Planning for location of another training school for mentally-retarded children in South Carolina was recommended recently by Dr. B. O. Whitten, superintendent of Whitten Village, near Clinton.

Whitten told the committee on Mental Health and Institutions the school should be located in the vicinity of Charleston so it could be near the facilities of the state medical college.

Whitten Village is at capacity now, he said, with a long waiting list.

He also suggested that provision be made at the new institution for aphasics and emotionally-disturbed children because Whitten Village cannot accept them at present.

Whitten said he realized the new institution could not come "over night" but said plans for it should be formulated now.

Also appearing before the committee was Dr. William S. Hall, superintendent of the State Hospital and acting superintendent of Pineland Training School for Negroes. Hall reported Pineland now has 404 trainees, 44 more than capacity, with 140 on the waiting list.

He told the group the institution needs additional aids and a number of building needs, including an infirmary-hospital and two dormitories. Estimated cost was \$1,000,000.

The committee also heard from John Zuidema, mental health consultant with the S. C. Mental Health Commission who will work with the group during its study of the mentally-retarded. He recommended that when no community resources exist, placing the children in institutions "is often the only resource." But, he said, he feels the committee should place special emphasis on the community services "which can make institutional placement unnecessary for most retardates."

In reply to questioning, Zuidema said there is not enough rehabilitation of those in institutions now and with more emphasis on this phase, space could be cleared for others.

THE MONTH IN WASHINGTON

The federal government is offering states liberal matching funds to provide health care for needy and near-needy persons 65 years of age and older.

The program, which Congress approved in the bob-tailed post-convention session, is supported by the American Medical Association and allied health groups.

Congressional approval of the federal-state program marked a victory for the medical profession and a defeat for Democratic Presidential Nominee John F. Kennedy, the AFL-CIO and other advocates of the Social Security approach to the problem.

In a key vote on the issue, the Senate rejected by a 51-44 vote a Kennedy proposal that would have provided hospitalization and medical care for the aged under the Social Security system. The Kennedy plan would have required an increase in payroll taxes.

Republicans and Southern Democrats joined in the Senate to defeat the Social Security approach which was opposed vigorously by the medical profession.

Under the legislation as signed into law by President Eisenhower, (1) substantial increases are authorized in federal grants to states to help with health care expenses of the 2.4 million persons on old age assistance rolls, and

(2) Federal matching funds are offered the states

to finance a new program of health care for an estimated 10 million aged persons who are not on relief but whose incomes may be inadequate to take care of all their health costs.

Start of the program was authorized for October 1 for those states where new state legislation is not required.

Administration of the program rests entirely with the states, subject to Federal approval in broad terms. It is up to each individual state whether it participates. Eligibility standards for beneficiaries and what health care services are provided are matters for the states to decide.

If a state so chooses, it can take care of all the health needs of an eligible beneficiary. The law authorized in-patient hospital services; skilled nursing home services; physicians' services; outpatient or clinic services; home care services; private duty nursing services; physical therapy and related services; dental services; laboratory and x-ray services; prescribed drugs, eyeglasses, dentures and prosthetic devices; diagnostic screening and preventive services, and any other medical care or remedial care recognized under state law.

For medical expenses of persons on old age assistance rolls, the federal government will contribute 50 to 80 per cent—with states with low per capita income getting the larger percentages of federal aid—of an amount equal to \$12 multiplied by the number of old age assistance recipients in a particular state.

The matching formula will be the same for financing the health care of the near-needy but there is no \$12 limitation figure.

Health, Education and Welfare officials estimated first-year costs of the program at \$262 million—\$202 million federal and \$60 million state. Annual costs are estimated to rise by the end of the fifth year to \$340 million federal and \$180 million state. However, these estimates admittedly are no more than educated guesstimates because so much depends upon state action.

It was estimated that in South Carolina maximum participation and a state contribution of \$2,000 would bring in \$1.6 million in federal matching funds in the first year of the program.

A. M. A. Washington Office

The Annual Meeting of the South Carolina Pediatric Society was held at the Hotel Columbia, Columbia, South Carolina on September 12 and 13, 1960. Dr. Charles H. Zemp, Jr., President, presided. Guest speakers were Dr. Nelson K. Ordway, Professor of Pediatrics, Yale University School of Medicine and Dr. Lawson Wilkins, Professor of Pediatrics and Director of Endocrine Section of Department of Pediatrics, Johns Hopkins. Member speakers were Dr. William Weston, Jr., Dr. Ann Morgan and Dr. Walter M. Hart. The last gave a report on the White House Conference.

BLUE CROSS - BLUE SHIELD

Two new color slide films and a black and white 16 mm movie are now available from South Carolina Blue Cross-Blue Shield for showing to employees, Service Clubs and other local groups.

"Little Herman's Operation", the Blue Cross Film, explains the major factors contributing to the cost of hospital care and reviews the remarkable progress that has been achieved in hospital care during the past twenty years, the Film depicts step by step the story of a typical hospital operation.

"The Guardians", pertaining to Blue Shield, points up the importance of medical care in our daily lives and presents an historical review of medical practice from ancient times until the present.

"Decision", another Blue Cross movie depicts the problems of cost as confronted by the hospital administration and the Board of Trustees. The Film was produced in a hospital and graphically illustrates the functions of the different departments and their importance in providing care for patients.

Any organization wishing to arrange for a speaker and film showing is invited to contact the Public Relations Department, Blue Cross - Blue Shield, 709 Saluda Avenue, Columbia, South Carolina.

ANNOUNCEMENTS

DUKE POSTGRADUATE CRUISE

The 5th Medical Seminar Cruise to the West Indies sponsored by Duke University School of Medicine will be held November 9-18, 1960. The medical seminar constitutes 20 hours credit of acceptable Category I Postgraduate Requirements A.A.G.P. A certificate for the number of hours of credit will be issued if desired. Instruction will be held on board ship, *M. S. Kungsholm*, and the program should be of interest to the specialist as well as the generalist.

For further medical details, address Director of Postgraduate Education, Duke University School of Medicine, Durham, North Carolina. For registration and cruise information, write Allen Travel Service, Inc., 565 Fifth Avenue, New York 17, N. Y.

The *Kungsholm* leaves from New York November 9th. Rates from \$230.

UNC SCHOOL OF MEDICINE FOURTH ANNUAL SYMPOSIUM November 17-18 — Chapel Hill

Postgraduate Course in Gastroenterology
Small Group Teaching and Panel Discussions Will Be
Emphasized

In Studying Diseases Causing Primary or Secondary
Disturbances of Digestive Tract Functions

Staffed by the Division of Gastroenterology and the
Department of Surgery of the UNC School of
Medicine, and guest participants.

The Department of Ophthalmology, Emory University School of Medicine, will sponsor a post graduate course in ophthalmic surgery to be held on December 1 and 2, 1960, in the auditorium of the Grady Memorial Hospital, Atlanta, Georgia.

Dr. Frank D. Costenbader, Senior Attending and Chairman of the Department of Ophthalmology, Children's Hospital, and Senior Attending Ophthalmologist, Washington Hospital Center, Washington, D. C.; Dr. John M. McLean, Professor of Ophthalmology, Cornell University School of Medicine, New York, New York; and Dr. Harold G. Scheie, Professor of Ophthalmology, University of Pennsylvania School of Medicine, Philadelphia, Pennsylvania will be the guest lecturers.

Diagnostic principles and techniques, preoperative and postoperative management, and surgical principles and techniques in extraocular muscle surgery, cataract surgery and glaucoma surgery will be discussed by this distinguished faculty.

Four national courses to train medical and health personnel for emergency services will be held during the current fiscal year by the U. S. Public Health Service and the Office of Civil and Defense Mobilization.

Three of the courses are being offered for the first time. These will be for hospital administrators, registered nurses, and environmental health personnel. The fourth is a repetition of basic health mobilization training for physicians and health-related professions which was introduced to the public last April, May, and June.

All courses cover basic civil defense concepts, current information on biological, chemical, and radiological warfare, and community disaster planning. Emergency services training includes the setup and operation of a Civil Defense Emergency Hospital, treatment of water to make it safe for use, decontamination of food and milk, mass casualty care, and medical self-help. Faculty will be composed of governmental and nongovernmental experts in the respective fields.

Tuition and housing are provided without cost to students and approximately one-half the necessary travel expenses can be reimbursed through OCDM student training expense funds. Enrollments are limited to permit proper student-faculty ratios. Applications should be made through State Civil Defense Directors.

Courses scheduled are:

1. Health Mobilization Program for Emergency Hospital Management, December 4-9, 1960, OCDM Eastern Instructor Training Center, Brooklyn, New York. (Course carries professional endorsement of the American Hospital Association.)

2. Nursing Aspects of Health Mobilization, April 23-28, 1961, OCDM Staff College, Battle Creek, Michigan.
3. Environmental Health Aspects of Health Mobilization, April 23-28, 1961, Battle Creek, Michigan. (Courses 2 and 3 held concurrently to permit joint sessions in some subjects.)
4. Health Services Aspects of Health Mobilization, May 7-12, 1961, OCDM Eastern Instructor Training Center, Brooklyn, New York.

Further information on training courses and other Health Mobilization activities may be obtained from State Health Departments or Civil Defense Offices, or from Regional Offices of either the Department of Health, Education, and Welfare or Office of Civil and Defense Mobilization.

SOUTHERN MEDICAL ASSOCIATION

St. Louis, Missouri — October 31-November 3, 1960
FOR INFORMATION AND RESERVATIONS

Convention Reservation Bureau
Southern Medical Association
911 Locust Street, Room 406
Saint Louis 1, Missouri

SOUTHERN SOCIETY FOR PEDIATRIC RESEARCH

A new Southern Society for Pediatric Research has been formed and will hold its first meeting on October 29 and 30 in Nashville.

The aim of the new organization will be to promote basic and clinical research oriented toward the field of pediatrics in the southern region and to serve as a forum for those interested in Pediatric education. This meeting will be open. Full time and part time members of Pediatric Departments, practitioners, and residents are invited. The membership will probably be elective.

SOUTHEASTERN STATES 1960 CANCER SEMINAR

17 Lake Street, Orlando, Fla
Cherry Plaza
November 16-18

**ELEVENTH COUNTY MEDICAL SOCIETIES
CONFERENCE ON DISASTER
MEDICAL CARE
FEATURING
USPHS HEALTH MOBILIZATION
FOR DISASTER
SPONSORED BY
COUNCIL ON NATIONAL SECURITY
AMERICAN MEDICAL ASSOCIATION
NOVEMBER 4-6, 1960
PALMER HOUSE, CHICAGO**

Premature Demonstration Center
Jackson Memorial Hospital, Miami, Florida
December 15-16, 1960—two-day course for
physicians.

Intensive program on latest development in care, management and theory of the problems of prematurity. (credit by American Academy of General Practice to be announced later).

This program will include lectures and demonstrations on various phases of premature care. There will be discussions on feeding, skin care, infection, handicaps of prematurity. Practical experience will be a part of the course.

Additional information from:

Bureau of Maternal and Child Health
Florida State Board of Health
Post Office Box 210
Jacksonville 1, Florida

ACADEMY OF GENERAL PRACTICE

The Mecklenburg County Chapter of the North Carolina Academy of General Practice announces a Post-Graduate Seminar with Round-Table discussions at the Hotel Charlotte, Charlotte, N. C., Nov. 3, 1960. Six hours of Category I credit. The morning session will include talks by Dr. James Donaldson of Temple University, Dr. Isadore Dyer of Tulane, Dr. Edward Litin of the Mayo Clinic, and Dr. W. C. Davison of Duke University. The afternoon will be given over to three round-tables and will be concluded by a reception at 5:30 p. m.

DEATHS

DR. E. E. HERLONG

Dr. Everette Eldrede Herlong, 64, of Rock Hill died August 6th at the York County Hospital after an illness of several months.

Dr. Herlong was born in Saluda and reared in Johnston. He was a graduate of Wofford College, the South Carolina Medical School, and was fellow associate of the College of Surgery in Philadelphia. He practiced medicine in Florence for three years and moved to Rock Hill in February, 1929.

He was a member of South Carolina and York County Medical Associations; was a past president of the Lions Club, past member of the Rotary Club, past president of the South Carolina Urology Association, past member of the board of trustees of Rock Hill School District, and for 15 years was team physician for the Rock Hill Bearcats.

DR. WILLIAM E. BICKLEY

Dr. William E. Bickley, 69, who had practiced medicine in Pendleton and Anderson County for 36 years, died August 7th at a Valdosta, Ga. hospital.

Dr. and Mrs. Bickley were visiting a daughter in Valdosta when he became ill.

A native of Newberry County, he was a graduate of

Newberry College and the Medical College of the University of Maryland.

He was a veteran of both World Wars and received the Distinguished Service Cross and the Silver Star in World War I.

DR. CLARENCE M. WORKMAN

Dr. Clarence M. Workman, Sr., 71, physician of Cross Anchor, died at his home August 15th. Death was attributed to a heart attack.

Dr. Workman had been a practicing physician in the Cross Anchor and Enoree community for the past 48 years, 20 years of which he operated an office at Riverdale Mills in Enoree.

Dr. Workman was a graduate of Furman University. He graduated from the Medical College of South Carolina where he was a member of Alpha Kappa Kappa fraternity.

After graduation from Furman he played for the Greenville Spinners and was a member of their league championship team in 1910. He continued to play pro ball until he was signed by the Cleveland Indians, when he decided to give up baseball to study medicine. Dr. Workman is listed in "Who's Who" in American medical doctors.

Survivors include his son Dr. Clarence M. Workman, Jr., a surgeon in Greenville.

DR. C. W. BAILEY

Dr. C. Williams Bailey, 64, who retired last July after 37 years as one of Spartanburg's leading pediatricians, died at his home in Boca Raton, Fla., of a heart attack.

Dr. Bailey left his practice in Spartanburg last year to join his son, C. W. Bailey, Jr. in the real estate business in Florida.

He was reportedly one of Spartanburg's first recognized pediatricians and was instrumental in stemming a diphtheria epidemic over 25 years ago. He maintained an office on Hall Street until the time of his retirement.

Dr. Bailey came to Spartanburg in 1923, just two years out of the South Carolina Medical College at Charleston.

His first practice was with Dr. C. Lesesne Smith (Dr. Lesesne Smith's father) in Saluda, N. C.

Dr. Bailey was born in 1896 at Georgetown.

The physician was a member of the American Academy of Pediatrics, the American Board of Pediatricians and the American Medical Association.

He was a member of the South Carolina Medical Association and Past President of the Spartanburg County Medical Society.

DR. W. R. BARRON

Dr. William R. Barron, retired physician and religious leader and long a dedicated citizen of the community of Columbia, died August 5th at his home. He had not been in good health for several years.

Dr. Barron was born September 7, 1883 in Man-

ning. He was a graduate of the Medical College of the State of South Carolina in the class of 1908. The first physician in South Carolina to specialize in urology, Dr. Barron entered the fulltime specialty in this field in Columbia in 1914. He was one of the founders and charter members of the Southeastern Urologic Association. He was also a member of the American Urological Association, the American Board of Urology, the American Medical Association, Southern Medical Association, S. C. Medical Association, and the Columbia Medical Society. In 1948, a portrait of Dr. Barron was presented to the Baptist Hospital by his friends among the medical and nursing professions and the laity.

Dr. Barron manifested his interest for many years in various phases of Columbia's life, but especially in the medical and in the religious. In 1947, *The Recorder* of the Columbia Medical Society of Richland County paid tribute to Dr. Barron and in the concluding paragraph it was said, "Seldom is the love of humanity and the practice of the Golden Rule so reflected in the life and work of any one man."

FROM THE PRESS

DR. W. R. BARRON

A Christian gentleman, unafraid. Such was Dr. William R. Barron, beloved physician, devout churchman and staunch civic leader, whose earthly life is ended, but whose fine influence will live on through his good deeds.

Skilled in his profession, and widely recognized in the field of urology, in which he pioneered in this state, he enjoyed for years a large practice, but he was never too busy to give of his time and talents to the cause of the Christian religion, nor too engaged to participate in any movement he thought was for the betterment of Columbia and South Carolina. He was a great believer in good government and was willing to fight courageously for it. He knew no compromise with wrong.

A Presbyterian who held the highest offices within the gift of his church in South Carolina, and who was a pillar in his own Arsenal Hill congregation in Columbia, he was also a foremost leader in interdenominational lay work in this state.

Doctor Barron had been a member of the board of The State-Record Company since 1937, and for three years had been vice president. His wise counsel will be greatly missed by his associates, as will be the pleasant contacts many of us have enjoyed with him for years.

A kind man with a generous heart, Doctor Barron liked people and people liked him. He was a person of courteous manner, whose acquaintances were from all walks of life. There was none too poor to obtain his expert professional services; none too humble for him to call friend. So, as he is laid to eternal rest in Elmwood this afternoon, there to await "the glorious

reveille," there are many to look back on their association with him, and to join in paying revered tribute to his honored memory.

—*The State*
(Columbia, S. C.)

DOCTOR'S ADVICE

A physician's timely warning to doctors against over-charging their patients should apply, of course, in any line of free enterprise.

In most business, competition establishes fair rates. In some cases, government regulations fix the amount of profit, especially in so-called monopolies such as public utilities. In other lines, the policy is to charge whatever the traffic will bear.

When it comes to illness, a patient cannot, safely refrain from consulting a doctor as he might deny himself a luxury that he cannot afford. When life is at stake, money seems less important.

For these reasons we applaud the remarks of Dr. Joseph P. Cain, president of the South Carolina Medical Association, in addressing the opening session of the Medical College of South Carolina. Dr. Cain said he was confident that most Americans do not want socialized medicine.

From what we have heard about socialized medicine in other countries, we believe it is not good either for patients or for physicians. Self-discipline among doctors themselves is more desirable than government interference.

Years of training are necessary for competent practice of medicine. We do not begrudge doctors—or anyone else—a good living. We join Dr. Cain, however, in urging professional men to resist the temptation to let "enthusiasm for high fees" overrun good judgment. The advice is good for other professions, too.

—*The News and Courier*
(Charleston)

ASSOCIATE COUNCILLORS OF THE SOUTHERN MEDICAL ASSOCIATION

South Carolina

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Dr. R. W. Hanckel, 96-A Bull Street, Charleston

Dr. D. Strother Pope, 1116 Henderson Street, Columbia 5

Dr. Thomas F. Stanfield, 126 East Earle, Anderson

Dr. J. Howard Stokes, 161 West Cheves Street, Florence

NEW CLINICAL CENTER STUDIES ON COLON AND RECTAL CARCINOMA

The cooperation of physicians is requested in studies on colon and rectal carcinoma recently initiated at the Clinical Center, National Institutes of Health, Bethesda, Maryland. Encouraging results in the treatment of gastrointestinal carcinoma have been reported using the pyrimidine analogues 5-fluorouracil and 5-fluorodeoxyuridine. However, other reports have raised the question of their effectiveness.

Patients can be accepted for these studies if they are ambulatory, have normal leukocyte count, renal and hepatic function and if they have metastases in the lung, peripheral lymph nodes (such as supra-clavicular or cervical) or skin.

Referrals of such patients will be greatly appreciated. Physicians who wish to have their patients considered for study at the National Cancer Institute may write or call:

Dr. Clyde O. Brindley

or

Dr. Paul P. Carbone

National Cancer Institute

Bethesda 14, Maryland

(OLiver 6-4000, Ext. 4251)


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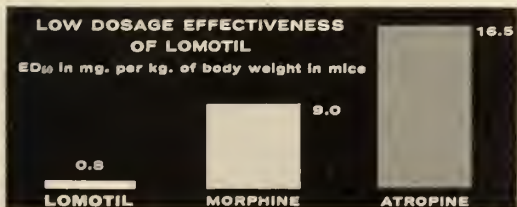
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Research in the Service of Medicine

BOOK REVIEWS

PRACTICAL PROCTOLOGY. By Louis A. Buie, M. D. 2nd Edition. Charles C. Thomas. Springfield, Ill. 1960. Pp. 737. Price \$22.50.

For the doctors of this state, this book by a famous proctologist who was born in South Carolina will naturally possess a special attraction. For all progressive doctors who desire to learn more about the anorectum, the seat of painful and, often, serious trouble, *Practical Proctology* will merit a particular appeal.

This easily read book, fully measuring up to its title, can be heartily recommended as a practical guide in the management of proctologic disorders. Simply expressed and readily understood, the pages abound with helpful pointers in diagnosis and treatment, and reflect the sound concepts which have made Dr. Buie world famous. As Dr. Buie states in the preface, the book, "is based on the practical experience derived from almost forty years of devotion to a specialty that few were willing to regard as such when the author entered it."

Many times and in a variety of ways, Dr. Buie plugs for more thorough examinations of the anorectum. One such paragraph is a standout: "Why is it that some physicians are so reluctant to examine the rectum? Is it because they believe that they are being considerate of the feelings of their patient who feels that the experience is unpleasant and embarrassing, or is it because physicians themselves have such a profound aversion for the experience? At the risk of editorial criticism, but to emphasize the importance of the physician's attitude, I will add the following: I will gladly insert my finger into the rectum of a person, professionally, with whom I would not care to shake hands, socially. Furthermore, when an adult person consults me regarding rectal disability, I assume that he has a carcinoma until it is proved that one does or does not exist".

This well illustrated book is a classic. *Practical Proctology* seems destined to become a venerated authority for proctologists and a valued source of enlightenment for others seeking knowledge of proctology.

Leon Banov, Jr., M. D.

PARDON MY SNEEZE: THE STORY OF ALLERGY by Milton Millman, M. D., Frye and Smith Limited, San Diego, California, 1960. 215 pp. Price \$4.00.

An understanding of allergy and the various influences involved in allergic disorders is often of great help to the patient in controlling his allergic problem more effectively. Adequate patient education by the physician who treats allergic disease does benefit most patients but because it is sometimes consuming, the physician cannot be as informative as

may be desired. An easily read and informative discussion of allergic disease would seem to be of great use for such a purpose.

This book is a very effective effort by the author to present to the lay public information regarding the allergic state and the mechanisms of allergy, the relationships of the autonomic nervous system to allergic disease, as well as information regarding the diagnosis and treatment of allergic diseases. In addition, discussion of food allergy, allergic disorders of the respiratory tract, and skin are well presented. Recommendations as to the avoidance of environmental allergens, the use of food diaries, and of diets are included. Many questions which come to the mind of the average patient with asthma or to the parent of the allergic child are clarified in easily understood explanation.

In the opinion of the reviewer, this volume is readable, informative, and accurate and may be recommended to those who desire more information concerning allergic disorders.

Kelly McKee, M. D.

THORACIC SURGERY BEFORE THE 20th CENTURY by Dr. Lew A. Hochberg, Vantage Press, Inc., New York 1, N. Y. 1960. Price .

This is an interesting account of the recorded knowledge pertaining to thoracic surgery since the beginning of time. It starts with the recordings pertaining to diseases of the chest in the so-called Smith Papyrus. Thereafter, the beliefs and teachings of all of the old well-known names including Hippocrates, Celsus, Galen, Paracelsus, Paré, Vesalius and numerous others are cited. From the end of the Dark Ages through the end of the 19th century there are numerous further quotes and an array of numerous well-known and lesser well-known names, including those of Velpeau, Laennec, Larrey, Estlander and Schede. Since thoracic surgery as we know it today is of fairly recent development, of necessity the work treats of endless descriptions of injuries including fractures and wounds, and of infections. Of course the treatment of empyema occupies a great part of the volume. There are numerous illustrations of all types of cannulae and trocars, knives and cauteries that were ever devised to deal with the drainage of fluid in the pleural cavity. In addition to the chapters pertaining to thoracic surgery in its various phases, there are extremely interesting chapters on the contributions to the advancement of thoracic surgery, consisting of physical diagnosis, antiseptics, and asepsis, anesthesia, pulmonary function, endoscopy and x-rays. The work appears to be completely authoritative. The bibliography is extensive and the index is exhaustive.

It is recommended highly as a reference for anyone interested in the more remote history of thoracic surgery.

Edward F. Parker, M. D.

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PERI-NATAL MORTALITY IN CHARLESTON, S. C.

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Associate in Obstetrics and Gynecology,

Medical College of South Carolina

Charleston, S. C.

Because the dangers of childbirth have been reduced markedly in the last ten to twenty years, more attention is being directed toward fetal salvage. In 1957 in the U. S. fewer than 4 mothers in 10,000 did not live to raise their children. Better obstetrical care has reduced maternal mortality about 95 percent in the last two decades. Reductions in fetal and neonatal deaths have occurred simultaneously as an indirect dividend of this improved care.

This study covers the five year interval—January 1, 1954 through December 31, 1958, in three private white hospitals (Private Pavilion of Roper Hospital, St. Francis Xavier Hospital, and Baker Memorial Hospital) and the colored service at Roper Hospital.

Perinatal mortality has been used as an all-inclusive term for all fetal and neonatal deaths during pregnancy, delivery, and the postnatal period. Only relatively recently a somewhat stricter definition has been accepted. This is mortality among fetuses or infants that weigh over 1,000 grams at birth, who die before delivery or before the end of the first week postpartum. One can readily see that this definition, being stricter, will make comparable surveys possible. This definition is superior to those using gestational age in weeks or infant length.

Most authorities^{1, 2} agree that infants of less than 1,000 grams seldom survive. This is due to immature development of the lung. After

this weight is reached, the infant has adequate development to survive extrauterine life.

In the period covered, there occurred 20,562 deliveries which produced 189 infants weighing less than 1,000 grams. In this group of 20,373 deliveries there were 591 perinatal deaths. (Table 1).

HOSPITAL	NO. DELIVERIES 1954-1958	NO. DEATHS
OLD ROPER	8020	331
NEW ROPER	4940	98
ST. FRANCIS	5476	117
BAKER	1937	45
	<hr/> 20373	<hr/> 591

It soon became apparent that we were faced with two entirely different groups of patients—the private patient and the indigent patient. Similar studies³⁻⁷ have reached the same conclusion that separation should be made.

There were 12,353 deliveries of infants weighing 1,000 grams or more with 260 deaths in the white patients group. There occurred 8,020 deliveries with 331 deaths in the colored group.

The perinatal mortality rate is computed as follows: (Table 2).

PERINATAL MORTALITY RATE

NEONATAL DEATHS AND FETAL DEATHS
1000 GMS AND OVER X 1000

LIVE BIRTHS AND FETAL DEATHS
1000 GMS AND OVER

TABLE 2

Neonatal deaths and fetal deaths over 1,000 grams x 1,000. Live births and fetal deaths over 1,000 grams.

The perinatal mortality rate for each of the hospitals studied is given in Table 3. The difference in perinatal mortality in the various private hospitals is not statistically significant

PERINATAL MORTALITY RATE

OLD ROPER	=	40/1000
NEW ROPER	=	19/1000
ST. FRANCIS	=	21/1000
BAKER	=	23/1000

TABLE 3

as computed by the chi-square formula (Dr. Gavan of the Department of Anatomy, Medical College of S. C.). However, the difference between the colored group and private white group is highly significant. (Table 4).



COLORED (331)	WHITE (260)
	
40/1000	21/1000

TABLE 4

There is practically no difference in percentage of premature deaths (infants less than 2,500 grams) in both groups. One hundred and forty eight deaths (57%) were in premature infants in the private group, compared to 193 (58%) prematures in the indigent group (Table 5).

MATURE VERSUS PREMATURE
WHITE INFANTS ~ COLORED INFANTS
112 (43%) MORE THAN 2500 GMS 138 (42%)
148 (57%) LESS THAN 2500 GMS 193 (58%)

TABLE 5

An interesting finding was the difference in percentage of antepartum deaths (fetal and intrapartum) to neonatal deaths (Table 6). Sixty five percent (216) of the indigent deaths and forty seven (123) percent of the private deaths were still-borns. This higher figure is in keeping with the larger number of colored mothers being admitted with late pregnancy complications having been unattended or treated by a mid-wife.

NO ABNORMAL STATE

WITH TOXEMIA
WITH DIABETES
WITH OTHER DISEASE
WITHOUT MATERNAL DISEASE

INFECTION

HYALINE MEMBRANE DISEASE

OTHER CAUSES

CLASSIFICATIONS of PERINATAL DEATHS

ANOXIA

ABRUPTION of PLACENTA
PLACENTA PREVIA
CORD
PROLONGED LABOR
OTHER (RUPTURED UTERUS)

MALFORMATIONS

ERYTHROBLASTOSIS

TRAUMATIC HEMORRHAGE (BIRTH INJURY)

The causes of these deaths were determined by examination of the charts of the mother and infant and autopsy protocols. The classifications of death was similar to the one used by Nesbitt³ and Potter.¹

This classification includes eight broad

ANTEPARTUM DEATHS		~	NEONATAL DEATHS	
WHITE INFANTS			COLORED INFANTS	
123 (47%)	ANTEPARTUM		216 (65%)	
135 (53%)	NEONATAL		115 (35%)	

TABLE 6

- groups:
- 1) Anoxia
 - 2) Malformations
 - 3) Blood dyscrasias (chiefly erythroblastosis)
 - 4) Traumatic hemorrhage
 - 5) No abnormal state
 - 6) Infection
 - 7) Abnormal pulmonary function (hyaline membrane)
 - 8) Other causes
1. *Anoxia*

There are many causes of anoxia during pregnancy, labor and delivery but premature separation of the placenta is the most common (Table 7). There occurred 22 deaths due

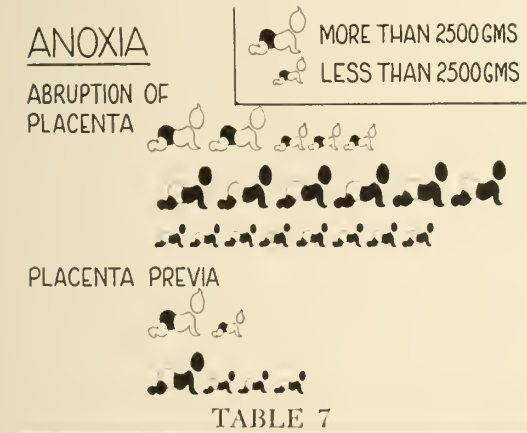


TABLE 7

to abruption placentae in the private group while 62 deaths due to this same cause occurred in the colored group (8% versus 19%). This difference is no doubt due to the large number of toxemias admitted to the colored obstetrical ward. It was extremely interesting to note that five of the colored mothers were delivered abdominally with known dead

fetuses due to the added complication of hypofibrogenemia with severe hemorrhage.

Placenta previa caused the death of 4 (1.5%) infants in the white group and 12 (4%) infants in the colored group. Prematurity was a very important factor in early delivery of these placenta previa infants as 14 of the total (16) were less than 2,500 grams.

The second most common cause of anoxia in this group of patients was prolapse of the umbilical cord (Table 8). This complication caused 18 deaths (7%) in the white group and 23 (7%) in the colored group of patients.

CORD COMPLICATIONS

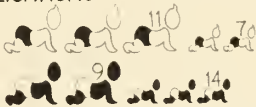


TABLE 8

Thirdly, prolonged labor or its complications was the next most important cause of deaths in the anoxia group. Eight infants (3%) died as a result of prolonged labor—one death in this group was an apparent direct result of intravenous pitocin stimulation with prolonged uterine contraction. This, however, was the only death in the entire group of 591 infants thought to be directly related to pitocin. Nineteen (6%) of the colored infants died as a result of prolonged labor.

Rupture of the uterus occurred once in the private group but occurred six times in the colored group.

2. Malformations

This group included only malformations which were incompatible with extra-uterine life (Table 9). There were 46 infants in this category of private patients (18%). In the colored group there were only 20 infants (6%). This increased rate of malformations in white private infants has been reported by others. There has been much experimental work in producing malformations in laboratory animals but little progress when actually ap-

MALFORMATIONS



ERYTHROBLASTOSIS



TABLE 9

plied to humans. We are all familiar with viruses as etiological agents for some malformations, particularly since the attention given to German measles. But there is little likelihood of damage to the embryo if the disease occurs after ten weeks of gestation.

There are many other causes of congenital malformations. Genetic defects inherited from the parents no doubt play an important role. Also to be considered are environmental factors within the genital tract of the mother. Attention is now being focused also on irradiation as an increasing factor in producing these defects. Lastly, the use of androgenic and progestational steroids have been incriminated by some investigators as causing varying degrees of virilization of the external genitalia of the female newborn.

3. Blood Dyscrasias

By far the most important group of infants in this category were the erythroblastic deaths. There were 18 (7%) infants in the white group and only 5 (1.5%) in the colored group. This is in keeping with the higher incidence of Rh negative mothers in the white race.

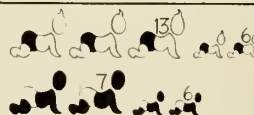
The frequency of fetal deaths from erythroblastosis among immunized women has shown no reduction and there is no way known at present by which these deaths can be prevented. The frequency of a fatal outcome in a live born non-hydrotic infant has been reduced recently since it has been recognized that a high blood bilirubin is the damaging agent and that this can be prevented by good pediatric care beginning at birth. Potter has estimated that the woman who has had one or more fetal deaths from erythroblastosis has

no more than a 10-20% chance of having a surviving child in the next pregnancy. The premature induction of labor if the cervix is ripe at 37-38 weeks or cesarean section should be considered if the husband is homozygous and there is a rising antibody titre. However, we have to avoid compounding the confusion by not terminating the pregnancy so early as to end up with a weak premature infant which will be a challenge to the pediatrician.

4. Traumatic Hemorrhage

This grouping of patients included spontaneous deliveries as well as difficult operative deliveries (Table 10)—all in fetuses with

TRAUMATIC HEMORRHAGE



NO ABNORMAL STATE

WITH TOXEMIA

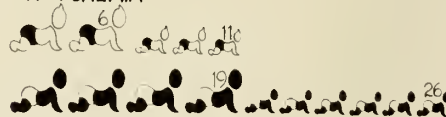


TABLE 10

intracranial or other types of traumatic hemorrhage. In the white group there were 19 (7%) neonatal deaths resulting from birth injury. There occurred only 13 (4%) such deaths in the colored group. In going through the data one gets the impression that more difficult forceps application occurred in the private group. There appeared more frequently also in the private group evidence of too early intervention or attempt at delivery without adequate pelvimetry studies.

The patient who has a contracted pelvis or a large baby can be allowed an intelligent test of labor and if good progress fails to occur abdominal delivery can be done safely. There is no place in modern obstetrics for the application of forceps on the unengaged head. Version and extraction has about completely disappeared except for delivery of the second twin.

5. No Abnormal State

As previously mentioned this category of

infants showed no abnormal state on examination but were divided into four groups:

- 1. With toxemia,
- 2. With diabetes,
- 3. With other diseases such as pyelonephritis, infectious hepatitis, perforated appendix, etc.,
- 4. Without maternal disease.

This broad group was largest of the eight in both the white and colored patients making up 103 (39%) in the white and 124 (37%) in the colored.

The "with toxemia" group was much larger in the colored patients, 45 or 13.5% to 17 or 6.5% as one would expect. There is a much higher percentage of toxemic patients delivered in the colored division of Roper Hospital. Thirty seven of the 45 colored infants lost in this group were fetal deaths. This demonstrates the importance of timing the induction of labor in severely toxic patients. One has to decide which is safer for the infant, intrauterine or extrauterine existence.



TABLE 11

The "with diabetes" group showed little difference, 9 fetal deaths (3%) in the private patients and 5 fetal deaths (1.5%) in the colored group. The trend recently has been to induce labor if the cervix were favorable at 38 weeks gestation. If the cervix were not favorable abdominal delivery was advised to avoid fetal death in utero during the last two weeks of pregnancy. (Table 11)

The "with other disease" group was made up chiefly of infants whose mothers had renal disease. Pyelonephritis was the most common type.

The fourth and most important group of infants without abnormal state were infants

born of mothers without maternal disease. This is the largest single group in the series. These are the patients who succumbed for no obvious reason. One hundred and eight of the patients (55 white and 53 colored) had spontaneous onset of premature labor with loss of the premature infant. The etiology of this premature labor is obscure as is the cause of the onset of term labor. The incidence of premature delivery is higher in the colored group as has been reported in other indigent groups. Eight to nine percent of deliveries in colored patients in Roper Hospital were infants of less than 2,500 grams. The percentage of premature deliveries in private practice is nearer six per cent. In many instances efforts were made to stop premature labor with large doses of opiates. Here the difficulty was compounded by delivery of a narcotized premature infant. It has been emphasized that more prematures could be salvaged by the avoidance of analgesics than by any one pediatric measure.

6. Infection

Intrauterine infection of the fetus most commonly takes the form of pneumonia and is almost always caused by bacteria in the amniotic fluid which is aspirated by the fetus. Six infants (2.3%) in the white group died because of pulmonary infections primarily. Twenty five infants (6%) in the colored group were lost because of this same reason (Table 12). Pro-

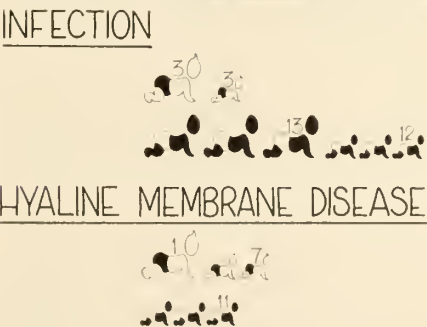


TABLE 12

longed or desultory labor may produce hypoxia in the fetus and increase the likelihood of aspiration of amniotic fluid. After premature rupture of membranes antibiotic therapy throughout the latent period does nothing to prevent intra-partum infection, nor does it

have a beneficial effect upon reducing perinatal mortality. It is the usual policy to give antibiotic therapy intensively during labor and the puerperium. Infective lesions which cause death within the first three or four days after birth have usually been contracted intra-partum. Infants more than a few days old may meet for the first time with infections from other sources than the mother.

An infection relatively mild in a mature infant may be fatal to one which is premature. Premature infants are very susceptible to respiratory tract infections.

Hyaline Membrane

This diagnosis was made in 8 (3%) white infants and in 11 (3%) colored infants. The etiology of this syndrome is obscure but the two most popular theories are:

- 1.) The hyaline material is a transudate from the blood vessels in the alveoli.
- 2.) This material is aspirated amniotic fluid.

The incidence is thought to have lessened since the use of lessened oxygen concentration in premature incubators. The use of a sodium bicarbonate solution intravenously has recently been reported as helpful in this condition.

Table 13 shows the autopsy percentage in

AUTOPSY PERCENTAGE

COLORED ROOPER	[331]	225 = 68%
WHITE ROOPER	[98]	56 = 57%
ST. FRANCIS	[117]	32 = 27%
BAKER	[45]	15 = 33%
TOTAL	[591]	328 = 56%

TABLE 13

each of the hospitals studied. Sixty eight percent of the colored deaths were studied post partum. This higher figure is due to follow up by the house-staff. The lower percentages in each of the private hospitals need to be improved.

Autopsies must continue to be energetically sought so as to expose the ultimate conditions responsible for death. Most parents are willing to grant autopsy permission when the im-

portance of the procedure is explained to them. We cannot expect our Pathology Department to cooperate if we send sketchy or no clinical information with the request for autopsy. For complete value of the postmortem examination all significant clinical facts should be recorded on the chart. Most Pathology Departments are overburdened and do not receive official credit for examination of newborns but cooperate when requested to help with the diagnosis. This, however, does not mean the routine request for examination of the 500 gram macerated stillborn infant. Routine requests for autopsies on this type of material rapidly produces a deterioration of interest on the part of the pathologist, particularly when no information is available and no one exhibits any clinical concern.

In 1958 a coordinated program with the Charleston County Health Department was begun in an effort to encourage earlier registration at prenatal clinics and encourage postpartum follow up examinations. The Public Health Nurses made daily rounds on the obstetrical wards discussing the problems of the patients. They held conferences in the clinic discussing conception, growth of the fetus, labor, child spacing and sibling rivalry. This program, plus the moving of the indigent patients to the Medical College Hospital, certainly should have some beneficial effect. It is planned to repeat this perinatal death study in the next five year period, 1959 through 1963.

During the five year interval of this study (1954-1958) fifteen mothers died in Charleston County. Thirteen of these mothers were colored and two were white (Table 14).

MATERNAL MORTALITY 1954-1958

15 MOTHERS DIED

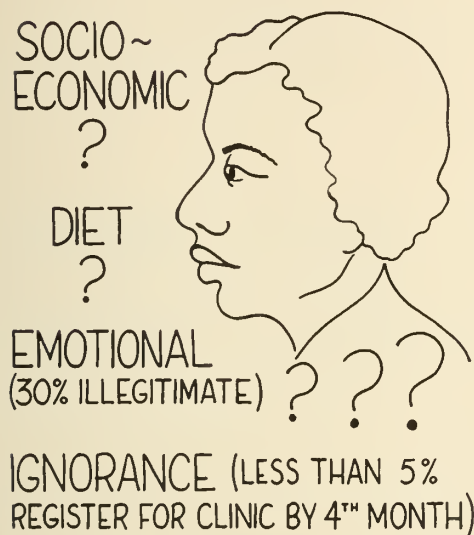


2 WHITE

13 COLORED

TABLE 14

WHY THE DIFFERENCE?



Why the tremendous difference, both in perinatal mortality and maternal mortality between the colored and white patient? We glibly theorize about socio-economic factors such as diet, lack of education, substandard living, etc. (Table 15). Obviously these colored patients are not receiving prenatal care and therefore get inadequate care. The physical facilities are present in the form of County Clinics and the Medical College Out-Patient Clinic. A recent study (Keummerer) showed that in 1958 less than 5% of the clinic maternity patients registered by the fourth month of gestation. The majority registered by the sixth or seventh month. These people have to be informed that care is available and should be taught to register early in pregnancy.

How important is the emotional factor? Approximately one third of these colored deaths were in illegitimate infants. This is in keeping with the rate of 32% illegitimacy in the colored birth statistics for 1958 compared with 4% for the white race in Charleston County. This means approximately one out of every three Negro children does not have a stable home. He will not have the proper food, clothes, schooling, moral training and emo-

tional security he needs. He will be a drain on the taxpayer from a health, education, delinquency and crime standpoint.

This study does not include those aftermaths of the reproductive failure problem such as cerebral palsy, epilepsy and mental retardation. Other areas of this problem were not studied such as: preventability, ratio of patients delivered by general men or specialists or the number of infants that died after seven days of life.

Summary and Conclusion

- 1). The perinatal deaths for the past five years in three private hospitals and one indigent service have been studied.
- 2). The causes of perinatal mortality need to be identified because they must also be the causes of congenital handicaps in infants who do not die.
- 3). The perinatal mortality rate is much higher in the indigent group as is maternal mortality and number of premature births.
- 4). It is believed that a reduction in perinatal mortality can occur with increased dissemination of knowledge of perinatal care to the indigent group of patients.
- 5). It is recommended that a code sheet be attached to every perinatal death chart so that the attending physician can record details of the patient's care while these details are fresh in his mind. All of us forget!!!

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GRISEOFULVIN AND PING PONG MYCOSIS—MONILIASIS

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The advent of an antibiotic effective against fungi is comparable to the appearance of penicillin some years ago. Griseofulvin is a welcome addition to our treatment of fungous diseases. But, like penicillin and the sulfonamide drugs, it has dangers and drawbacks, and it is not an unmixed blessing.

What is it? It is the fermentation product of *Penicillium griseofulvum*, *patulum*, and *janczewski*. Penicillin comes from *Penicillium notatum*. But, perhaps because griseofulvin does not contain nitrogen, cross-reactions have not been reported and it has been used safely in several penicillin-sensitive patients. It was discovered in 1939 and, like penicillin, was laid aside and forgotten. In 1946, practically rediscovered, it was used widely as an agricultural fungicide on lettuce and tomatoes. In 1958 Gentles reported on its experimental use in guinea pigs and there the "anti-serendipity" finally ended and human trial showed marked value for fungous infections of the skin, hair, and nails.

How does it act? It is a "single-minded" narrow spectrum antibiotic, acting only on trichophyton, microsporum and epidermophyton fungi which ordinarily grow in the keratin layers of the skin. We must remember that the skin is constantly growing outward, the effluvium of the keratin-horn cells being steadily cast off. The fungous infection has to grow and penetrate inward faster than the keratin grows outward. Griseofulvin is absorbed from the gastrointestinal tract and is deposited in concentration in the keratin of skin, hair, and nails sufficiently to be fungistatic. It produces gross distortion, thickening and curling of the hyphae. Cure is complete only when the viable but inactive fungi are gradually exfoliated and replaced by uninfected tissue.

Since it is able to inactivate only the super-



ficial fungi of the skin, hair, and nails, it does not help deep fungous infections. It also tends to produce secondary yeast or monilial infections just like other antibiotics and has no effect on the growth of monilia (candida).

Since it comes from one of the *penicillium* molds, the question of cross-sensitization and danger of use in patients highly sensitive to regular penicillin was considered. So far, experimental use in a number of penicillin-sensitive patients has not produced any reactions. Penicillinase, specific for penicillin, does not have any effect on griseofulvin in the body. It is therefore probably as safe as any other drug in penicillin-sensitive patients.

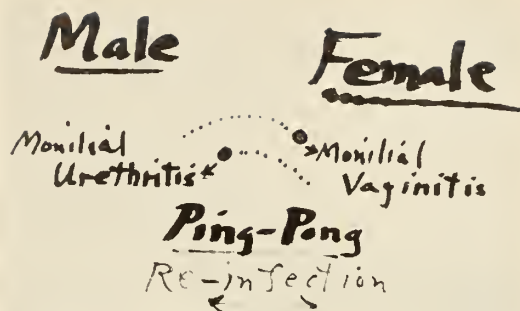
Indications: Griseofulvin does not affect the growth of bacteria and yeasts or monilia (*candida albicans*). It also does not affect superficial tinea versicolor (probably because this group of fungi do not penetrate deeply enough to enter the zone where new keratin is formed). Apparently the presence of fungi in

the skin inhibits the growth of monilia. Also, monilia and fungi may coexist as a double infection with the monilium as underdog and subclinical in activity until the balance of inhibition is lifted by removal of fungal depression by treatment of various kinds, after which monilia may grow in great profusion, unhindered by adverse circumstances. Monilia do not have much "get up and go" and are easily discouraged, but when conditions are ideal, they cause much inflammation and trouble. Monilia are often present without symptoms in the vagina and sometimes in the urethra of the male, which leads to marital ping-ponging of infection. Recent work has also demonstrated that in many families where one person has *T. rubrum* fungous infection, small patches of fungus may be demonstrated in up to 60% of the rest of the family groups. (Recent work in India by DeSai).

Since griseofulvin is so efficacious in simple fungous infections, the diagnosis must be established by an examination of the scrapings, softened by warmed 20% potassium hydroxide, under the microscope, and if at all possible, by culture on Sabouraud's medium. On this medium both fungi and monilia grow well and the presence of one or both may easily be demonstrated. Incubation is not necessary. Small perfume bottle culture media can be purchased cheaply at surgical supply houses for this purpose. (In my office, we make up 500 of these at a time and discard the bottle when the culture has been finished). All one needs to do is to scrape the infected skin onto a slide for immediate examination and into the culture vial for later identification.

The importance of knowing the diagnosis is illustrated by the fact that local treatment is always necessary, even during the period of administration of the antibiotic. Also, the treatment must take care of both fungi and yeasts, if necessary, and sometimes a bacterial infection. This is particularly true of acute vesicular eruptions of the feet which respond ordinarily to old-fashioned local treatment and the use of expensive griseofulvin is not justified.

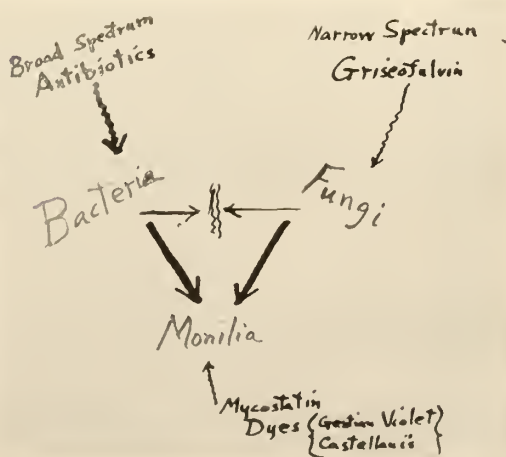
To have a clinical diagnosis completely established, one must find hyphae (the growing active phase of the fungus); the growth



must be in the deeper layer of the skin where new keratin is formed; moisture for growth must be present; and there must be some keratin defect or faulty immunity which allows the fungus to grow in the patient's skin. Under these circumstances, griseofulvin is justified and, unless there is intolerance, it should be given. The optimum dose is still four tablets of 250 mg. or one gram daily. Less than this increases failures. Resistance so far has not been reported.

Contraindications: Urticaria, erythema multiforme, generalized erythrodermia have been reported, sometimes very severe. Headache and nausea can usually be controlled while continuing the drug. A blood count and urinalysis should be done before instituting treatment and should be repeated twice monthly as indicated. So far, there is no cross-sensitivity with penicillin.

Monilia flareup in the griseofulvin-penetrated skin is becoming more common and



often results in an acute wet dermatitis. Ping-pong reinfection of each infection may continue for a long time. Several illustrative cases follow.

CASE 1. Adult male 60 years old, with dry skin and a crural dry scaling eruption was given griseofulvin in adequate dosage for one month. He then began to have severe itching, acute wet erythema and vesicles, with scattered border pustules in the periphery of the pubic and thigh areas. This then produced a general scaly erythematovesicular autosensitization dermatitis over the rest of the body which required heavy corticosteroid therapy to control, in addition to local treatment of the skin to resolve the monilial infection which was proved by culturing the skin. In this instance there were several flareups, one of which showed fungi again and required carbol-fuchsin paint to control. The senile dry skin required a good deal of followup care before the eruption subsided.

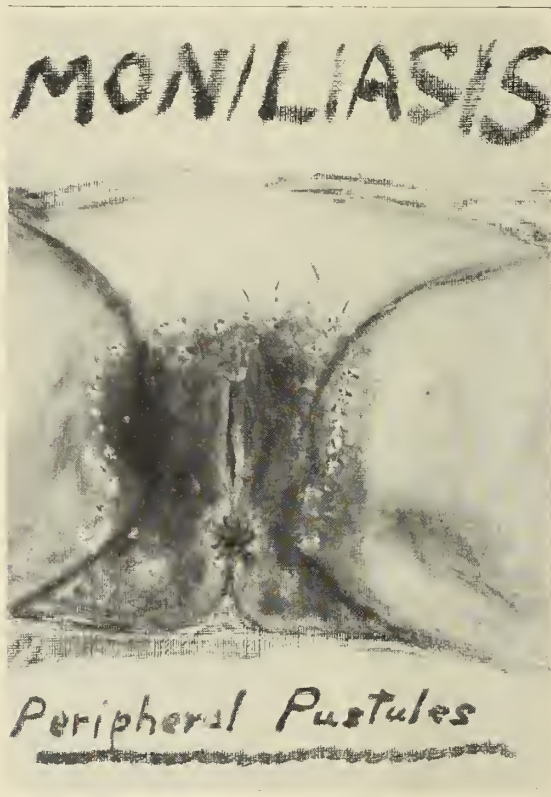
CASE 2: Boy, 16, developed crural dermatitis which showed fungi in scrapings and on culture. He was given griseofulvin and local fungicides and was almost clear three weeks later when he began to have acute redness and vesicular eruption of the crural, thighs, and extension of dermatitis on to the scrotum (this area is almost always immune to mycotic invasion in ordinary cases). Culture showed a heavy growth of monilia and treatment with mycostatin ointments rapidly cleared it up. Treatment was discontinued but the monilial infection flared up several times and treatment with monilicides was necessary for three weeks more.

CASE 3: Male, married, age 35. In fall of 1959 he developed an acute erythema of the crural areas and was given griseofulvin for a month. The condition improved temporarily, then flared acutely with vesicopustules, and involvement of the scrotum. Fungicidal treatment made this worse. Cultures later showed monilia and on treatment with mycostatin lotions, the condition cleared up. Several weeks later the condition recurred, and scrapings showed hyphae of fungus infection but treatment for this made him worse. Recurrent attacks continued for two months, during which time he cleared up at intervals. Patch tests to medications and clothing were negative. Several cultures at intervals showed monilia. His wife was examined and found to harbor an asymptomatic monilial infection of the vagina. She was treated with mycostatin suppositories and with douches to stop the marital ping-ponging of the infection and the patient cleared up and has since remained clear. The problem is much more troublesome in the female as a rule.

Recent Experience: Within a week after stopping griseofulvin, fungi may often be cultured from the skin. This calls for continued treatment long enough to be sure that the fungi in the keratin, even though stunted and curled up, can be entirely cast off from the

skin. This may be achieved more rapidly by local treatment with mild peeling standard fungicidal topical agents.

2. Fungous infections of the scalp show the same stunting in the hairshafts and the hairs should be shaved from the scalp every week, carefully putting the clippings into paper and burning them. The purpose of this is to avoid reinfection from the patient's own hairs. Average treatment is one gram a day for eight weeks. Single dose methods are not quite as



good. However, repeat infections seem, so far, to respond to a second course of griseofulvin as well as in the beginning. Resistance, so far, is not a problem.

3. On smooth skin treatment for four weeks is usually sufficient, especially if mild peeling locally with resorcin and salicylic acid, in cream or lotion, is also used to rid the keratin of the frustrated fungi.

4. Fingernails grow much more rapidly than toenails. Thus a course of three or four months may take care of fingernail mycosis where seven months may be necessary for toenails. Some surgeons are now avulsing the nails

while giving griseofulvin. Results are good but this is a rather heroic and unnecessary extension of treatment. The nails may be continually scraped down (in the office with electric dental bur) at home with a sharp-edged piece of glass (microscope slide or go out in back yard and bust a bottle on a rock.) Dr. O'Leary of Mayo Clinic always suggested pieces of broken light bulb, the glass being thin enough to break easily and not cut so severely, while at the same time being firm enough for scraping.

5. Acute Foot Dermatitis is as often a contact, sweating maceration, other infection, etc. as it is a fungous infection and local treatment is still the best. Chronic, dry, mycotic infection of the feet (negative patch test for shoe dye sensitivity and positive culture for fungus) does justify the use of griseofulvin.

6. Superficial tinea versicolor macules on the chest do not penetrate deeply enough into the new keratin-forming layer and are therefore not improved by griseofulvin treatment. Local use of griseofulvin ointment is now being tried (previous use was not found very helpful) to see if enough penetration of the superficial layer may be achieved. The problem of resistant and persistent spores is the chief trouble here.

7. One must keep in mind the fact that Tinea tonsurans has, in the past few years, come up from "South of the Border" to cause

ringworm of *adult* scalps. In very persistent, chronic seborrheic dermatitis, it may pay to culture the hairs (there is no fluorescence under black light with this fungus) and if the infection is present, give griseofulvin. This was a very resistant infection to older methods of treatment.

8. There is apparently no effect on spermatogenesis. This has been thoroughly studied in adult males. Studies have not been completed on prepuberty stage but indications are that the drug, in the dosages now being given, is quite safe. Spermatogenic effects in rats were due only to relatively enormous dosage.

Summary:

1. Be sure of the diagnosis by doing microscopic examination and culturing the tissue.

2. If monilial infection is present, treat it first with mycostatin, dyes, wet dressings and carbol-fuchsin paint. Unwise administration, "in the dark", with griseofulvin may cause acute general flareup and severe dermatitis. This is most dangerous in hot weather.

3. Help the systemic treatment along by mild exfoliation and peeling off the infected skin, nail, or hair to get rid of stultified but still viable fungus in the keratin layers.

4. Griseofulvin, while not the panacea hoped for, is still one of the most valuable antibiotics to appear since penicillin and should be used with masterful reasonableness whenever it is definitely indicated in the control of fungous infections.

THE INCOMPETENT INTERNAL CERVICAL OS:

A Review of the Current Literature

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The etiology of abortion lies anywhere within the conditions needed to be fulfilled for a conception to reach maturity. Most conceptions result in a normal infant, however some women are not so fortunate. To them, an abortion is a serious and depressing affair. What can be done for this woman? Over the years the problem of abortion has been of foremost interest in the minds of obstetricians and gynecologists. Because of such interest and investigation a relatively new etiologic syndrome has been advanced, that of the incompetent internal cervical os. This is characterized clinically by the story of a woman with multiple pregnancies, a very few of which come to term or even produce a premature viable child. In the late second or early third trimester there is a sudden rupture of the membranes followed by a rapid and relatively painless extrusion of the products of conception.

Aschoff in 1906 demonstrated the intimate anatomy of the uterus and cervix, showing that the upper part of the cervical canal and the anatomical internal os were incorporated into the lower segment of the uterus at an early stage of pregnancy. However, between the anatomical internal os and the lower uterine segment is a fibromuscular junction and it is this area that plays the important role of maintaining the pregnancy in utero. When the isthmus begins to unfold in the late second and third trimester of pregnancy, it is this accumulation of cervical muscle which acts as a compressor and prevents premature herniation of the membranes. In a careful anatomical study the precocious movement of this circular layer of muscle in a case of habitual abortion was observed by Hughesdon.⁵

How is this condition diagnosed? The history is the most important clue. A history of

repeated pregnancies and their untimely loss near viability, especially with the factor of premature rupture of the membranes is most suspicious. Usually these women conceive easily and generally carry the pregnancy uneventfully until the latter part of the second trimester. At this time there is a sudden unexplained rupture of the membranes followed by premature labor and loss of the fetus. This recurs repeatedly in the same woman, usually in the same way. What has happened is that the fibromuscular junction has been unable to retain the growing conceptus, the membranes have herniated through a partially opened cervix which has painlessly and progressively effaced itself and dilated. This occurs in the absence of uterine contractions, bloody discharge or discomfort. One can see these insidious changes taking place in the cervix by examining these patients at weekly intervals starting after the 14th week.

There are other methods of diagnosis. With an anatomical defect in the region of the internal os, Palmer⁶ states that an 8 mm. Hegar dilator should traverse the internal os in the non-pregnant uterus without resistance. Durfee³ prefers to use an olive tip sound. If there is a failure of the integrity of the internal os the olive tip of the sound moves in and out of the uterine cavity with great ease. This is not true of the normal state in which the sound passes into the uterus with difficulty and is removed with even greater difficulty because the tip hangs up at the level of the internal os. Interestingly, such instrumentation of the cervix with this defect causes almost no pain to the patient.

According to Lash and Lash⁴ the pathology may be palpated most easily following an abortion. With the finger in the cervical canal a defect in the form of a thin scar can be pal-

pated. This is usually anterior in the Lash's experience. With the bladder dissected off the cervix, the thin scar is especially evident with the defect varying from 1 to 2 cm. in width and 2 to 3 cm. in length. There are two radiographic methods to demonstrate the defect.¹¹ In the first technique, a balloon is inserted into the uterus over a Best-Mixer canula and with traction on the balloon the cervico-uterine angle and its integrity is outlined. The second method is that which utilizes a Rubin canula and lipiodal. In the normal uterus, the Rubin canula tip completely fills the internal os and there is no flow of lipiodal into the cervical canal around the canula tip. In the presence of an incompetent cervical os the reverse is true. When the canula tip is removed another picture will demonstrate any widening of the internal os as the lipiodol runs out of the uterus.

The etiology of the incompetent internal os is usually associated with trauma: a curettage with too much zeal; a dilatation (probably over dilatation with resulting laceration); previous abortion followed by curettage; vaginal hysterotomy; precipitate labors; lower cesarean section; Dührssen's incisions. According to Heaney "the greatest contributing factors, in my experience to this condition are tearing of the cervix by labor or by instrumental dilatation . . ." The frequency with which the incompetent cervix is encountered is estimated to be 3 times per 1000 deliveries.

Initial efforts at surgical repair of this condition were first done as early as 1941. The first reported repair in the American literature was in 1950 by Lash *et al.*⁶ This first technique was a simple pleating of the thinned out portion of the cervix at the level of the internal os where the defect was noted, performed immediately after abortion. The next type of repair included the removal of an elliptical segment of cervical tissue without destroying the continuity of the external os after which reconstruction of the cervical canal was accomplished. At present Lash utilizes a wide resection of the upper middle third of the cervix, extending into the lower uterine segment, which is then closed by a double layer of sutures.

All of these processes produce scarring of

the area, which is the background of the hope for prevention of relaxation and dilatation of the cervix. Suture material has ranged from kangaroo tendon or catgut to fine tantalum wire. The repair is now carried out 3 to 4 months following the abortion. Baden¹ has utilized the principle of trachelorrhaphy during pregnancy with good success.

In 1954 at the International Congress on Obstetrics and Gynecology in Geneva, Shirodkar¹³ proposed a new repair. His reasoning was that the defect in the internal os was more frequently in positions other than the anterior cervix and thus a more logical repair would be a method of encirclement by means of a fascial strip forming a pursestring around the internal os. The great advantage of this procedure is that it can be accomplished during pregnancy and that it preserves pregnancy without endangering the patient's fertility. The fascia used as described by Shirodkar was that of the patient's fascia lata. The fascia, 1.5 cm. wide by 10 cm. long, is inserted beneath the vaginal mucosa at the region of the internal os by means of the following technique:

Under general or regional anesthesia with the patient in Trendelenburg position the anterior lip is grasped with a sponge forcep. A transverse incision is made in the vaginal-cervical junction and the submucosa and bladder are pushed upwards to expose the region of the histological internal os, which lies about 1½ inches above the external os. The posterior lip is now grasped and a small vertical incision is made at the same site on the posterior surface of the cervix. The submucosa is bluntly deviated to the right and left and then by means of special instruments such as large aneurysmal needles or Gallie fascial needles, the fascia is guided into place and is sutured at the level of the internal os. The fascia is then tied and is anchored anteriorly and posteriorly by means of catgut sutures.

Since Shirodkar's publication many modifications of this technique have been introduced. Durfee³ now uses prepared ox fascia and ties the ox fascia anteriorly before anchoring the fascia in place. The objection to the use of ox fascia is that many people cannot tolerate this material, with a resultant sloughing of the fascia. In other cases failure has been reported due to complete absorption of the fascia with the loss of the fascia and consequent loss of the strengthening purse string. Page⁸ has further modified this procedure in

that he uses four strips of fascia. The mid-portion of each fascial strip is anchored at 3, 6, 9, and 12 o'clock and the ends are tied with the knots placed at 2, 5, 8 and 11 o'clock. In addition the area is sprinkled with talcum powder in order to increase granulation and strengthen the scarring. More recently the fascia has been replaced with synthetic fibers such as Mersiline, a synthetic dacron material originally designed for vascular grafts, and Permofil, a new inert protein non-allergenic material. At present Shirodkar has abandoned the use of fascia and uses a 3 mm. wide nylon tape and has experimented with kangaroo tendon. Green-Armytage and Brown⁴ prefer to use 7N or 8N nylon, tying the knot posteriorly in order to avoid irritation to the bladder. If need be, they have used a second or third nylon ligature, using as many as required to close the endocervical canal.

Most authors agree that the ideal time for the surgical repair is about the 18th or 22nd week of gestation. The procedure is not recommended in the first trimester because of the risk of abortion from other causes. Before undertaking the procedure it is felt that the patient should be examined at weekly intervals and effacement and dilatation confirmed to be occurring insidiously. Certainly the diagnosis of incompetency should never be made on the basis of a single examination. Riva¹¹ has performed the operation twice on the same patient during the same gestation, the second operation necessitated by a sloughing of the fascia shortly after the initial repair.

Considering Malpas⁷ statement that after 3 abortions the chance of carrying a pregnancy to term was 27 per cent, the results of the operation are very encouraging. Riva when he first presented his figures in 1956, had raised

the fetal salvage from 17.4% to 45.4% in his first group of patients. Since then in his series of 50 patients, 40 have been successfully delivered of a viable baby. In 1957 Green-Armytage and Browne⁴ report 100% success in 7 patients. Durfee³ reports a fetal salvage of 70% in a group of 24 women whose previous salvage rate was 20%.

The majority of operators advise delivery by cesarian section. Those utilizing ox fascia have permitted the patient to deliver vaginally but keeping in mind the occasional necessity of cutting the fascia to prevent uterine rupture. Once the fascia has been cut the cervix is again rendered incompetent and in all likelihood, a repair will be required with the next pregnancy. The authors using Mersiline vary in their methods of delivery. About one half prefer to deliver their patients by section and the others cut the Mersiline gauze at time of labor.

Reduction of premature infant mortality and morbidity is one of the goals most sought after in modern obstetrics. Support of the incompetent cervix offers great hope in reducing fetal wastage by preventing the birth of a near viable child. However unless rigid criteria are established as to the indication for cervical re-enforcement and great care exercised in the selection of patients, it is easily possible that the hoped for reward of a viable infant may result in abuse of a sound procedure.

It must be repeated again and again that the number of patients who have true incompetence of the cervix is extremely limited. The operation is of benefit to only a very few patients. It is no panacea except for a very specific type of abortion. In these select patients, it affords the woman a promising method to restore her natural childbearing function.

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Somatopsychic Disorders. Vince Moseley (Charleston) Tri-State M. J. V. 8; 6-10 (May, 1960)

Although students of psychosomatic disease have contributed much towards a better appreciation and understanding of the unity of relationships between soma, psyche, and spiritual factors, practicing physicians must be continually aware that patients may present dominant psychiatric or emotional manifestations as a result of disturbances of internal homeostatic mechanisms, and when due to a curable disease, the primary management is medical. Local lesions effecting the central nervous system of various etiology, endocrine disturbances and renal or hepatic disease may be initially manifested as derangements in emotional or psychic areas.

The energy requirements for cerebral or nervous function are chiefly derived from glucose oxidation, any disturbance relating to glucose concentrations or factors which interfere with substrate oxidation produce mild to severe impairment in cerebral function and, in severer degree, anatomical injury or death. Disturbances in tissue oxidation resulting from such factors as iron deficiency or anemia are frequently accompanied by disturbed nervous function. Pulmonary and cardio-vascular disease often produce dramatic cerebral dysfunction.

Dietary deficiency such as those in thiamine or nicotinic acid deficiency states are common examples of metabolic disturbances which produce psychic manifestations.

Trace metal metabolism is an area in which expanding knowledge indicates the importance of minute quantities of certain of the metallic ions for the integrity of enzymatic functions intimately related to cerebral metabolism. Of interest are recent studies which indicate that repeated exposure to high concentrations of alcohol may result in depletion of zinc with impairment of dehydrogenase activity in the liver and hippocampal area of the brain.

Disorders of transmission of neural impulses such as were first recognized in relationship to acetylcholine at the ganglionic sites in peripheral nerve function is now recognized as also active in central nervous system synaptic function and may be responsible for certain emotional alterations. The brain and nervous system, despite the placid and pallid appearance of these structures, participate in very delicately bal-

anced thermo-dynamic processes which are continually active. Tonus is determined by active neuronal participation for contracture and relaxation of muscular structures.

The frontal cortex, is now thought to exert more a modifying influence of an anticipatory or planning type rather than being the site for actual elaboration of those impulses and responses which are recognized as being emotional. Human observations and animal experiments in recent years indicate that the fronto-temporal cortex area of the brain in association with various specific sites of the limbic system are responsible for emotional reactions and concomitant autonomic responses.

Although specific emotions may be enumerated in a rather lengthy list with some overlapping, it appears that all may be placed in two actually well defined categories, namely those which relate to self-preservation and those which relate to preservation of the species. Changes in emotion are accompanied by a variety of physiological alterations such as those related to temperature regulations, cardiac rate and rhythm, vasomotor responses, and changes in tonus of muscle in various structures of the body. It may be considered that the changes which are going on are representative of or a symbolic representation of information which the individual, in terms of human biology may have utilized in a more overtly expressive manner in an earlier evolutionary stage as indicators or signals of his response to an emotional stimulus. The vegetative nervous system is intimately associated with the transmission of impulses both for the initiation and regression of such activity, and should not be thought of in terms of autonomic response but reacts to higher brain centers of stimulation.

A better understanding of the internal environment or homeostasis and the effects of distant structures and their inter-relationships on cellular metabolism combined with the newer knowledge of neuro-physiology and neuropharmacology are fields which are rapidly rendering obsolete the division of disease concepts into the organic and functional, and provide the framework of area for all aspects of human behavior to be related to a unitary concept; the end result of all disease in some degree relates to derangement in function.

PLASMA SUBSTITUTES

A REVIEW

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Introduction

Transfusion of whole blood or pooled plasma represents the theoretically ideal replacement therapy in most hemorrhagic or shock states. Adverse features, however, such as limited availability, brief storage periods, typing reactions, virus transmission, etc. continue to direct interest toward substitute products. The inadequacies of low molecular weight crystalloids such as saline and glucose have been well recognized. High polymer colloids have been used for 60 years in conditions which do not require immediate infusion of blood cells. Plant and animal colloids are cheap, stable and can be sterilized but they frequently produce histamine-release reactions, hemostatic defects, clumping of blood elements, tissue storage with associated pathology, etc. When such reactions are reduced to an acceptable minimum, as might be the case with dextran at the present time, consideration can be given to the development of variations with different half-lives in the circulation. For example, a relatively short half-life is most suitable when a plasma substitute is used as interim therapy until whole blood can be obtained. A long half-life under these circumstances can lead to hypervolemia following the blood transfusion and this in turn can cause congestive heart failure if the myocardium has been significantly weakened. The following review is intended to present experimental and clinical experience with the more important colloids which have been used in the past, are being used at present or give prospect of future use.

ACACIA

Acacia or gum arabic is obtained from the sap of the African acacia tree and consists of arabinose, galactose, galactosoglucuronic acid and rhamnose in the form of calcium, magnesium and potassium salts. Its molecular

weight is about 1500 but it is highly aggregated in concentrated solutions with a number average particle weight of 17,000 to 120,000 as determined by osmotic pressure.¹ Solutions of acacia in saline were used experimentally before 1900 and extensively during World War I. Amberson¹ has reviewed the reports of its use in more than 1800 patients with favorable results. Bayliss² claimed the injection of acacia is not associated with any serious toxic effect, noting only an *in vitro* agglutination of erythrocytes. Even a recent report³ has suggested that it is superior to polyvinylpyrrolidone in the expansion of blood volume following hemorrhage in rabbits. However, the administration of acacia to bled dogs results in a mortality rate as great as in untreated animals.⁴ Studdiford⁵ noted tachycardia, cyanosis, dyspnea, pulmonary edema and 2 deaths in the administration of acacia to 3 patients. He observed similar reactions in dogs accompanied by aggregation of erythrocytes and increased erythrocyte sedimentation rate (ESR). The intravenous administration of acacia results in transient but profound hypotension in dogs^{6, 7} and respiratory distress in guinea pigs.⁸ Although Amberson¹ suggested that these reactions were caused by the use of impure samples, a recent report⁹ has demonstrated that the hypotension which follows the injection of acacia in dogs is at least partially mediated by a massive release of histamine. In this report⁹ it was observed that hypotensive reactions to initial injections of acacia conferred immunity to subsequent injections for several days but that clumping of erythrocytes was not prevented during this tachyphylactic period. Accompanying the hypotension and clumping there is a fall in the oxygen content of blood which has been ascribed to a coating of the erythrocyte interfering with its oxygenation.¹⁰ A defect in the hemostatic mechanisms also occurs as evi-

denced by an increase in bleeding time.¹¹⁻¹³ Furthermore, acacia although it contains calcium has the capacity of adsorbing more calcium from blood and additionally altering its potassium and magnesium concentrations.¹⁴ When injected, acacia is not metabolized but is stored in the liver, spleen, lymph nodes, kidney and bone marrow.^{11, 15-18} This storage phenomenon is associated with liver damage greatly reducing the formation of plasma proteins and retarding their regeneration following hemorrhage.^{12, 13, 16-19} Furthermore the formation of foam cells and atheromatous lesions with large doses has been described.¹¹ The clinical and experimental experience with acacia has been well reviewed by Gropper *et al.*²⁰ The discovery of more efficient and less toxic colloidal solutions has resulted in the clinical abandonment of acacia although it is occasionally used experimentally as a suspending agent for intravenous administration of insoluble substances.

METHYLCELLULOSE

The parenteral administration of methylcellulose has not been strongly advocated although at least one group^{21, 22} has suggested its use as a plasma substitute. They noticed however that repeated administration of small doses produced anemia, increased plasma viscosity, increased ESR, persistent myeloid leukocytosis and prolongation of coagulation time. Furthermore, it is subject to tissue storage and produces a thesaurosis characterized by foam-cellular atheromatous changes in the arteries of rabbits and dogs similar to that caused by acacia. The storage phenomenon is also evidenced by prolonged anemia, leukopenia or leukocytosis, impaired coagulation and hemorrhagic diathesis, thrombopenia and a marked decrease in serum albumin and globulin.^{11, 22, 23} Heuper^{11, 23} has suggested that the mechanism involved in the production of the atheromatous lesions is the formation of films which interfere with the oxygenation of vessel walls. Similar reactions and thesauroses have been described following injections of hydroxyethylcellulose.²⁴ In a recent investigation⁹ small injections of methylcellulose produced rapid fatalities in dogs by what appeared to be an obstructive phenomenon re-

lated perhaps to the extremely high viscosity of methylcellulose solutions.

PECTIN

Pectin is a mixed polysaccharide composed of acetic acid, arabinose, galactose, galacturonic acid, methanol and xylose.²⁵ It has a molecular weight of 100,000 to 250,000 but can be fractionated by autoclaving to more suitable molecular weights.²⁶ Its use as a plasma substitute was suggested during World War II²⁵ and in a report of its use in 155 patients²⁷ storage in spleen, kidneys, liver and lungs was noted. The review by Gropper *et al.*²⁰ suggests that pectin is retained in the circulation at least 4 hours after injection but is cleared within 7 days. However, others have reported prolonged storage^{28, 29} producing foam-cellular atheromatosis.^{23, 30} The administration of pectin solutions to bled dogs results in 100% mortality.⁴ Its administration increases capillary permeability and produces hypoprothrombinemia, hypofibrinogenemia and thrombocytopenia.³¹ Extreme reactivity, storage and low efficiency have prevented clinical acceptance of pectin solutions.

HEMOGLOBIN

The use of solutions of hemoglobin in saline has been reviewed by Amberson.¹ Human hemoglobin in saline has been shown to be superior to dog plasma in supporting the circulation following moderate hemorrhage in dogs.³² However, its rapid conversion to methemoglobin and disappearance from the circulation, interference with renal function, storage in liver and spleen, production of increased ESR and other toxic effects have prevented extensive clinical use.^{1, 20, 26}

MODIFIED HUMAN GLOBIN

The use of human globin extracted from erythrocytes as a plasma substitute has been suggested by Strumia.³³ The derived protein has a molecular weight of 34,000 and 30 Gm of globin can be obtained from one pint of blood as compared with 15 Gm of plasma protein.²⁶ From the red cells now discarded it has been estimated that 6,000,000 16 Gm units of globin could be obtained.²⁰ Gropper *et al.*²⁰ have reviewed its use in 108 patients without reactions. In the dog, however, globin pre-

pared from dog blood has been found to produce respiratory distress and symptoms of histamine release.³² It is much less effective than saline in supporting the circulation of dogs following hemorrhage.^{32, 31} Globin has been discarded as a plasma substitute and finds no clinical use today.

GELATIN

Hogan³⁵ in 1915 reported on the administration of gelatin to 7 patients in shock. The solution seemed to be of benefit and no deleterious effects were noted. The interest in gelatin during World War I was not great however due to the antigenicity and the possible transmission of tetanus and anthrax.²⁸ There are several commercial brands of gelatin for parenteral use currently available, most of which are derived from the collagen of the hard bones of cattle and fractionated by autoclaving to average molecular weights below 40,000.²⁹ It would seem that a protein would be an ideal colloid for use as a plasma substitute as it would be similar to plasma proteins.

It has been reported that gelatin does not maintain blood volume as adequately as dextran in bled rabbits and in normovolemic patients^{3, 36} but the efficiency of gelatin as a plasma substitute seems to vary greatly with the method of assay. An excellent measure of the usefulness of volume expanders is the bleeding volume index (BVI). To determine the BVI an animal is bled to a specific end point and then the colloid is infused either immediately or after a period of hypotension. After a specific time interval the animal is bled to the same end point again and the ratio of the volume of blood obtained at the second bleeding to that obtained initially is the BVI. In a study of the efficiency of plasma substitutes in dogs utilizing BVI,³⁴ gelatin was found to be superior to plasma and polyvinylpyrrolidone (PVP) but inferior to dextran and albumin. In a study of survival following hemorrhage and replacement in dogs,³⁷ gelatin appeared superior to dextran and PVP. In this study it was found that if gelatin were used as the replacement fluid, the hemoglobin concentration could be reduced to 20% of control with a survival of greater than 50%.

In another survival study¹ gelatin had a survival rate of 60% as compared with 94% with heparinized plasma, 74% with serum, 50% with citrated blood, 42% with saline, 30% with citrated plasma and 12% untreated. Using serial hemorrhages and replacement, Levinson *et al*³⁸ noted excellent results, with hemodilution the only deleterious effect. One defect of gelatin seems to be that it is rapidly eliminated from the circulation. When one liter of 5% osseous gelatin is infused into patients at a rate of 300 ml/hour, only 55% of the injected gelatin is present at the end of the infusion and the plasma levels decline from 780 mg/100 ml at the end of the infusion to 300 mg/100 ml at 24 hours.³⁹ This might suggest the use of gelatin infusions for parenteral alimentation but the same article indicates that 80% of the infused gelatin is excreted within 72 hours, the excretion continuing for several days thereafter. Thus there is little or no catabolism of this colloid. Normal renal function is not necessary for the elimination of gelatin from plasma as the rate of decay of plasma gelatin concentrations is the same in normal and oliguric patients.⁴⁰ Groppe *et al*²⁰ in an extensive review of clinical reports conclude that gelatin is equivalent to plasma in the expansion of blood volume and survival following hemorrhage but note that there is some controversy as to its superiority to normal saline in burn shock.

There has been some discussion of the possibility of antibody formation to gelatin. Maurer⁴¹ has shown that there are normally occurring antibodies to gelatin in human serum and in the serum of the dog and other animals.⁴² The content of gelatin in the diet does not influence the antibody content of dog and rabbit serum.⁴³ These antibodies do not appear to have great clinical significance as there have been no reports of serious anaphylactic reactions to infusion of commercial gelatin. A recent investigation⁹ has shown that injections of 100 to 200 mg/kg of Plazmoid gelatin in normotensive dogs produce occasional brief moderate hypotensive reactions. The possibility of serum sickness following gelatin infusions remains an important consideration in the administration of these solutions.

Gelatin seems to be relatively non-toxic in comparison to some of the other colloids. Behrmann³¹ noted that gelatin infusions are not followed by increases in capillary permeability as observed following infusions of pectin, methylcellulose, dextran and PVP in dogs. Gelatin produces only slight pathological changes in patients²⁷ and Hueper¹¹ has reported that it does not produce the foam-cellular atheromatous thesaurosis typical of aca-cia, pectin and methylcellulose. Another group¹⁶ has reported some atherosclerotic changes and interstitial nephritis upon repeated administration of gelatin to dogs. Hartman²⁸ has reported a gelatin nephrosis of short duration in mice and Skinsnes¹⁶ noted frequent appearance of swollen kidneys with histological changes in the tubules of 32 patients who died after receiving 100 to 17,600 ml of gelatin. This appears to occur within one-half hour of the infusion and the kidney is restored to normal within 5 days. There is a close resemblance between this gelatin nephrosis and that produced by sucrose^{17, 18} and may be caused by absorption of gelatin into the tubule cells where it is then followed by water.¹⁶ The degree of renal impairment associated with this nephrosis is not clear however as Ravdin¹⁶ reported no change in glomerular or tubular function following administration of gelatin to dogs for 112 days and 1 to 2 liters of gelatin each day for one week to volunteers. Another study of normovolemic or bled volunteers⁵⁰ showed that hemodilution was the only ill effect of gelatin infusion.

Following gelatin infusions, aggregation of erythrocytes is greatly increased. Miller and Little⁵¹ have demonstrated the formation of flexible clumps of erythrocytes which break up readily. Another group⁵² observed increased ESR in dogs infused with gelatin. Perhaps the most extensive study of erythrocyte aggregation by gelatin has been made by Thorsén and Hint⁵³ who showed that 18,000 was the minimum molecular weight producing increased ESR and that the ESR is proportional to the molecular weight and concentration of gelatin. They also demonstrated the formation of a surface film on the blood cells following infusion.

Although there is some clinical use of gelatin solutions today, there seems to be a declining interest in unmodified gelatin.

MODIFIED FLUID GELATIN

A major inconvenience in the use of gelatin is that it is solid at room temperature and must be warmed before and during infusion. An attempt to eliminate this feature has been the development of a chemically modified heat-degraded gelatin—modified fluid gelatin (MFG) which is fluid at room temperature. In terms of the BVI, MFG appears to be slightly inferior to dextran when infused immediately following hemorrhage but superior to it when administered after a 60 minute period of hypotension at a mean blood pressure of 30 mm Hg.⁵⁴ A clinical study⁵⁵ of MFG has shown that the plasma concentration has decreased to one-third of control 4 hours following infusion but that the volume expansion has only been reduced to two-thirds of control. Another group⁵⁶ has found that 91% of infused MFG is retained after 4 hours and 88% after 24 hours. They also found that following hemorrhage and a period of hypotension MFG is about equal to autogenous blood as determined by BVI. Ravdin⁵⁷ has demonstrated a retention of 90% of the infused volume of MFG at 12 hours in oligemic volunteers. The retention was only 10% if they were normovolemic before infusion, indicating the importance of pre-infusion volemia in determining the persistence of plasma substitutes. Increases in capillary permeability following hemorrhage and replacement with MFG have been reported⁵⁸ to be associated with reduction in prothrombin, platelets and fibrinogen and prolongation of bleeding times. Modified fluid gelatin is not in widespread use today.

OXYPOLYGELATIN

Another attempt to modify gelatin has been to utilize condensation with glyoxal followed by oxidation with hydrogen peroxide producing oxypolygelatin (OPG) which is fluid at 10 to 13° C. When this product is administered to bled rabbits, 25 to 50% is retained for 6 hours.⁵⁹ In normal subjects given OPG the plasma concentrations decreased from 500 mg/100 ml at the end of infusion to

200 mg/100 ml within 4 hours.⁶⁰ Although this study showed good results using OPG in patients in shock, 5 of the 42 normal subjects experienced allergic reactions. In a review of several articles, Gropper *et al*²⁰ conclude that OPG is retained about 37% at 5 hours and 14% at 24 hours accompanied by a volume retention of 59% at 5 hours and 32% at 24 hours. Studies of survival in bled rabbits and dogs treated with OPG indicate that OPG is superior to plasma and dextran in rabbits⁴¹ and superior to dextran and PVP in dogs but inferior to Plazmoid gelatin and plasma in dogs.³⁷ Studies of BVI have shown that OPG is superior to plasma but inferior to blood in dogs³² and that it is inferior to dextran and MFG when replaced immediately following hemorrhage or after a period of hypotension.⁵¹ Increased ESR^{32, 60} and agglutination of erythrocytes⁶¹ have been observed following OPG infusions. A careful study of the aggregation of erythrocytes by OPG has been carried out by Feigen and Campbell⁶² who concluded that OPG is attached to cells by proton bonds and that the increased ESR is caused by interaction of long protein chains with reactive sites on the cells. They showed that sodium salicylate prevents this aggregation and suggest that this protection is mediated by a reaction of the salicylate with both the protein and the cell sites.

ISINGLASS

Isinglass, a gelatin derived from fish swim bladders, has been used without serious deleterious effects in patients.⁶³ The supposed advantage is avoidance of contamination by tetanus and anthrax. Gropper *et al*²⁰ in reviewing its use noted a 14% reaction rate in man.

BOVINE SERUM ALBUMIN

Bovine serum albumin has been given to 410 patients with 12 immediate anaphylactoid reactions consisting of hypotension and dyspnea or pyrogenic reactions and 38 delayed reactions with urticaria, erythema, arthralgia, fever, myalgia, etc.⁶⁴ Gropper *et al*²⁰ in reviewing the reports of infusions of bovine plasma noted a 15% reaction rate. Their review of extensive studies of deantigenation is not encouraging and this problem may well be the one factor preventing widespread use of the

many animal proteins which are readily available.

POLYVINYLPYRROLIDONE

Early in World War II, Hecht of the Bayer Company in Germany began research which led to the development of a new synthetic plasma substitute — polyvinylpyrrolidone (PVP).⁶⁵ PVP is synthesized from acetylene, ammonia and formaldehyde under pressure. The original product had a weight average molecular weight of 25,000 but the current American products have molecular weights between 33,000 and 56,000.²⁰ Renal excretion of PVP with a molecular weight of 15,000 or less is very rapid, but there is a sharp cutoff at 35,000 to 40,000.²⁰ Urinary excretion in patients has been estimated to be about 40% in 24 hours with a total excretion of not more than 60%.⁶⁶ The efficiency of PVP as determined by BVI seems to be very low in dogs—ranking less than plasma and OPG and being superior only to saline.³⁴ PVP has been found to be inferior to gelatin and dextran in volume maintenance in bled rabbits.³ In terms of survival it is inferior to gelatin and OPG and superior to dextran.³⁷

Reactions to PVP manifested by increased ESR^{67, 68} and hypotension and death in dogs⁶⁹ are frequent. Pretreatment with 35 ml/kg does not prevent dogs from reacting to 350 ml/kg. Graded doses of 8 to 210 ml/kg administered in 2 to 14 injections does decrease the response to larger doses. Pretreatment with massive doses gives almost complete protection against later injections. When the blue dye T1824 is injected before PVP, the intense erythema is accompanied by intense bluing.⁷⁰ Dialyzed PVP does not cause hypotension in tolerant dogs but the gross external signs appear. The response is characterized by vasodilation and hemoconcentration by increased permeability.⁷⁰ These effects have also been noted by Halpern *et al*⁷¹ who reported that promethazine inhibits to some extent the increased rates of water and protein filtration through capillary walls. PVP administered intraperitoneally is 100% absorbed in the rabbit within 8 hours and 90% absorbed in the dog within 9 hours. Although the ESR increased 11 fold in rabbits and 5 fold in dogs,

there were no other manifestations of an anaphylactoid reaction and this method of administration has been proposed for patients in cases where intravenous infusion would be impossible or impractical.⁷² Loubatières⁷³ reported shock and loss of consciousness following injections of 175 mg/kg in dogs and hypotension to 40% of control blood pressure with 750 mg/kg. He also noted an increase in coagulation time to 25 minutes. Halpern and Briot⁷⁴ have demonstrated an increase in plasma histamine from less than 20 microgm/l to above 350 microgm/l following administration of PVP to dogs. The increase in plasma histamine persisted for greater than 30 minutes and was accompanied by a decrease in blood pressure to 20 to 60 mm Hg. They also noted a large increase in the volume of gastric secretion and the concentration of free acid. Itching, edema, shock, hemoconcentration and refractoriness for 2 to 3 days followed the reaction. Administration of 1 to 18 mg/kg of PVP to dogs results in variable responses, but severe hypotension, hemoconcentration and skin flushing invariably follow the intravenous administration of 105 mg/kg.⁷⁵ The small molecular weight fraction (20,500) is active but the very large molecular weight fraction (560,000) is inactive in producing these responses.⁷⁵ A recent report from this laboratory⁷⁶ has demonstrated that doses of 1 to 350 mg/kg in dogs cause severe shock and that the response increases with increasing dosage. This response frequently persists for longer than one hour and is accompanied by increases in plasma histamine from control values of less than 63 microgm/l to levels of 2100 microgm/l. This response has been termed a "canine" reaction and thought by some to be species specific. However, it is highly probable that the dog is not unique but only more sensitive. High molecular weight (1,000,000) PVP is antigenic in man causing specific antibody formation.^{76, 77} This does not necessarily indicate that clinical PVP is antigenic and anaphylaxis probably plays no part in the reactions to PVP seen in the dog.

In the mouse 15 to 16% of injected PVP can be found in the carcass after 58 days. Most of this is in the pelt but some is in the liver,

muscles and bones.⁷⁸ Fractions of molecular weight 110,000 to 120,000 are stored for years although fractions of molecular weight 40,000 or below are excreted within a few days.⁷⁹ The severity of this prolonged storage has been demonstrated by studies of radiochromic phosphate capture by the reticuloendothelial system in rabbits given 350 mg/kg of PVP weekly for 12 weeks. Six weeks after the end of this procedure the rate of uptake of the chromic phosphate is 59% of control.⁸⁰ Rabbits given 16 injections of 350 mg/kg of PVP show splenomegaly with foam cells constituting one-third to one-half of the spleen and other storage phenomena in lymph nodes, bone marrow, adrenal medulla, lungs and blood vessels persisting in the reticuloendothelial system and endothelium for more than 4 weeks. This causes thrombosis and penetration of capillary walls with formation of granulomatous consolidation of the lung parenchyma.²⁰ Hartman²⁸ indicated that German army pathologists found damage to liver and kidneys in soldiers to whom PVP had been administered and advised against further use. Gropper *et al*²⁰ note that PVP has the capacity to bind certain molecules and reduce their absorption or excretion. They reviewed the use of PVP to retard the absorption of penicillin, insulin and other drugs and noted that it may be capable of binding toxins from diphtheria and clostridia and even viruses. In reviewing the literature they concluded that no reactions upon administration of PVP to man occur except in infants under 2 years of age. Drill²⁰ noted that one study has indicated no effect of PVP on renal or hepatic function in man even when administered in volumes up to 3,000 ml. Drill also noted that PVP may give false positive tests for albuminuria and contribute to the blood "sugar" as determined by reducing tests.

PVP was an innovation in the field of plasma substitutes by virtue of its synthetic source. The tissue storage reactions have prevented more widespread use of this substitute and it is rarely used in this country at this time.

POLYVINYLCALCOHOL

Gropper *et al*²⁰ reviewed several reports of the use of polyvinylalcohol (PVA) which ap-

pears to be inferior to PVP in the maintenance of blood volume following hemorrhage. Following the intraperitoneal or intravenous administration of PVA to dogs, atheromatous lesions of the aorta and carotid and femoral arteries develop which resemble cholesterol atheromatosis.⁸² Hueper suggested that PVA disturbs the oxidative metabolism and nutrition of vascular walls producing the lesion.⁸² In rats and rabbits PVA produces foamy cytoplasm histiocytes in skin, lungs, lymph nodes, Kupffer's cells and is even stored in neuroglia and ganglion cells of the brain.⁸³ This storage in the central nervous system is not seen with PVP which is excluded from the brain.⁷⁹ The endothelium of many vessels is covered by a layer of PVA which is accompanied by the development of proliferative and obliterative arteriolar lesions. The capillary endothelium in renal glomeruli are filled with swollen cells obliterating the lumen. This reaction also follows administration of acacia, methylcellulose and pectin.⁸³ Administration of PVA causes increased ESR, aggregation of erythrocytes and increased coagulation time.⁸¹ There has been no serious consideration of clinical use of PVA because it appears to be much less effective and more toxic than PVP.

DEXTRAN

Dextran was first recognized as a contaminant formed in the juices of sugar beets and other food products. In the nineteenth century it attracted attention by obstructing pipes through which sucrose juices were transported. Scheibler in the 1870's determined that it was a polymer of anhydroglucose units.⁸⁴ Dextran is formed from sucrose by the action of *Leuconostoc mesenteroides* and similar microorganisms. During the reaction fructose is split off from the sucrose leaving glucosyl radicals which react with the non-reducing end of growing chains. Free fructose is liberated in the reaction but very little free glucose is formed.⁸⁶ The synthesis does not require the mediation of any phosphorylated sugar⁸⁷ and can be carried out in the presence of a cell-free suspension of dextranase.⁸⁸ The basic structure of dextran is a branched polymer of alpha 1, 6 linked D-glucopyranose units. At points of branching there may be 1,

3 or 1, 4 bonds. The degree of branching is dependent on the strain of the organism as well as the culture characteristics. Dextran are characterized by a high degree of polydispersity. Native dextran produced by strain NRRL B-512 of *L. mesenteroides* has a molecular weight greater than 10,000,000. The molecules vary greatly in size and are branched flexible coils. Native dextrans produce very viscous solutions which mix poorly with water and are unsuitable for parenteral use. When injected as 1 to 3% solutions they cause death of experimental animals by diffuse thrombosis of small vessels.⁸⁵ The native dextrans are degraded by heat as the molecular size is monitored by viscosity or alcohol precipitation. Other methods of depolymerization include ultrasonic vibration, alternating electrical fields, gamma irradiation and the enzyme dextranase found in several microorganisms. After the dextran is degraded it is fractionated by alcohol precipitation which is not sharp and the resulting fractions are relatively inhomogeneous. If the number of individual molecules is determined by osmotic pressure or the number of reducing end groups the number average molecular weight can be derived. If physical constants of the colloid are determined such as intrinsic viscosity, sedimentation rate, light scattering, etc. the resulting information can be compared with other constants for similar solutions to obtain the weight average molecular weight. Low molecular weight particles have more influence on the number average and high molecular weight particles have more influence on the weight average molecular weight. Thus the weight average is always greater than the number average and the ratio of weight average to number average is a measure of polydispersity. Intrinsic viscosity is a measurement which is convenient and rapid but the regression of intrinsic viscosity on molecular weight varies greatly with the extent of branching and molecular dimensions. For dextran of a particular strain which is degraded and fractionated by carefully controlled procedures, intrinsic viscosity can be used to indicate molecular weight after more careful sedimentation equilibrium studies have been used to obtain the viscosity-molecu-

lar weight relationship. The American specifications now direct that the dextran must be fractionated by methanol precipitation so that the 10% containing the heaviest molecules and the 10% containing the lightest are separated. The weight average molecular weight of these two fractions must be determined by light scattering. The high 10% fraction must have a weight less than 200,000 and the low 10% fraction must have a weight greater than 25,000. The clinical preparation now manufactured at Pharmacia Ltd., Uppsala from a B-512 strain has a mean molecular weight of about 75,000 by light scattering. A fraction of this dextran with a molecular weight of 69,900 has been found to contain molecules which are roughly 3 times as long and one-half as broad as serum albumin. This dextran when purified is a faintly yellow powder which is soluble in water to 20%. Currently Sweden specifies that the weight average molecular weight by light scattering must be $80,000 \pm 10,000$, the intrinsic viscosity between 0.24 and 0.27, the nitrogen content less than 1 mg/100 ml, the pH between 4.0 and 7.0 and that it must be in a solution containing 0.9% sodium chloride or 5% glucose. (The above discussion has been largely derived from Grönwall⁸⁵ who has thoroughly reviewed the literature relating to the clinical use of dextran.) A 6% solution of clinical dextran manufactured by the Commercial Solvents Corporation has a viscosity of 2.5 to 3.5 centipoise at 25° C. In this country number average molecular weight is determined from the number of terminal anhydroglucose units, which contain a carbonyl group. The use of intrinsic viscosity is discouraged because of its dependence on polydispersity which varies with each sample.⁸⁶

Grönwall and Ingelman investigated the possible parenteral applications of degraded dextran during World War II.⁸⁰ They discovered that dextran solutions were the best plasma substitutes known at that time and initiated clinical usage which has grown steadily since their early work. The clinical result obtained with dextran is dependent upon the rate of its elimination from the blood and therefore upon the rate of its excretion into urine and its passage into lymph. This in

turn is almost solely determined by molecular weight as dextran is excreted solely by glomerular filtration without substantial tubular reabsorption.⁹¹ Two hours after administration of dextran to nephrectomized animals the plasma levels are 30% of control with fractions of molecular weight 10,600; 70% with 35,000; 85% with 91,700; and 90% with 135,000 to 412,000.⁹⁴ The plasma/lymph gradient is inversely proportional to molecular weight but even the 412,000 fraction penetrates the capillaries. The plasma/lymph gradient decreases as the amount infused increases⁹⁴ and 4 hours after infusion 80% of the initial volume expansion is maintained in bled dogs but only 25% in unbled animals.⁹⁵ This clearly demonstrates the great difficulty in evaluating reports of the efficiency of plasma substitutes as the procedure used is very important in determining the result. A careful study in patients receiving 500 ml of clinical dextran has shown that the blood concentration of dextran declines from 700 mg/100 ml at the end of the infusion to 300 mg/100 ml after 24 hours and to 175 mg/100 ml after 48 hours.⁹⁶ Thus it seems that dextran fulfills the requirements of the U. S. National Research Council that 50% of the infused plasma substitute must be present in the blood at the end of 12 hours.

Wilson *et al.*⁹⁷ reported excellent results with dextran in the therapy of oligemic and traumatic shock. Dextran is superior to OPG but inferior to plasma in the bled rabbit as determined by BVI and survival.⁶¹ Another report has shown it to be superior to acacia, gelatin and PVP in the maintenance of blood volume in bled rabbits.³ In bled dogs it is superior to gelatin, OPG, PVP and plasma and only slightly inferior to albumin and whole blood as determined by the BVI.³¹ Following replacement of extensive hemorrhage by dextran in the dog, 50% of the protein loss is replaced within 4 days.⁹⁸ The administration of dextran to volunteers is associated with increased cardiac output and prolonged elevations in right atrial and pulmonary arterial pressures⁹⁹ along with hemodilution which is gradually corrected.¹⁰⁰ In normovolemic dogs infused with 10 ml/kg of dextran there is a decrease in total circulating serum albumin to

60 to 70% of control within 30 minutes. This effect does not occur with infusions of dextran in bled animals.¹⁰¹ In bled dogs maintained at mean blood pressures of 40 mm Hg for 60 minutes, dextran is comparable to pooled dog plasma in maintenance of blood pressure.¹⁰² The restoration of lost hemoglobin is as rapid with dextran as with plasma and in 12 days amounts to an increase of 40% of the erythrocyte mass at the end of hemorrhage. Plasma protein regeneration is not retarded and amounts to a 100% increase in plasma protein mass in 12 to 14 days.¹⁰² The hemodilution and increased blood pressure seen upon infusion of dextran in normovolemic dogs is greater than that produced by saline or dextrose.¹⁰³ Thorsén however has shown that when dextran is administered the plasma volume may be increased, decreased or unchanged depending upon the preinfusion volume (greater expansion if hypovolemic), the colloidal osmotic pressure of the plasma (greater expansion if low colloidal osmotic pressure before infusion), and the amount of fluid outside the circulatory system (greater expansion if much available fluid.¹⁰⁴) Meyer *et al*¹⁰⁵ infused 500 ml of 6% dextran into normal volunteers and measured an increase in blood volume of 960 to 2850 ml with a mean of 1880 ml occurring in 1/4 to 6-1/4 hours of the infusion. This unusual degree of expansion is partially explained by the observation of Pirani *et al*¹⁰² that the colloidal osmotic pressure of 6% dextran is 50 to 100% greater than that of plasma.¹⁰² Also, Thorsén has demonstrated that the colloidal osmotic pressure of a mixture of plasma and dextran is greater than that expected from their individual osmolarities.¹⁰⁴ Using serial hemorrhages in dogs and replacement with plasma or dextran, Wise *et al*¹⁰⁶ found that there is a compensatory increase in cardiac output and arteriovenous oxygen difference although oxygen consumption decreases. The mechanisms compensating for hemodilution are rapidly exhausted when the hemoglobin falls to 50% of control and at this level there is evidence of tissue hypoxia. This is probably related to the empirical standards established during the Korean conflict for the mixing of infusions of dextran and blood when treating casualties.

Dextran alone was administered to a total volume of 1500 ml. If the infusion volume was 1500 to 4000 ml, dextran was administered equally with blood. If the volume was 4000 to 7000 ml, 2 units of blood were administered with each unit of dextran and the maximum dextran infusion was limited to 2½ liters.¹⁰⁷ In addition to its use in oligemic shock, dextran has been used in the hemoconcentration hypovolemia of burn shock.^{108, 109} Dextran seems to be an entirely acceptable therapeutic agent in these cases although the concomitant use of plasma prevents the decrease in plasma proteins associated with the use of dextran alone. Clinical reports have repeatedly claimed satisfactory response to the use of dextran in many types of shock.¹¹⁰ Acidosis however, is one factor in shock that is not as well treated with dextran as with plasma but this probably could be corrected by the addition of buffers to the dextran solutions.¹¹¹ Dextran is probably the most efficient artificial plasma substitute in use today and it is as acceptable as plasma in most cases.

In addition to urinary excretion, dextran is eliminated by catabolism. It has a metabolic half-life of about 6 days in mice. The carbon which is liberated is incorporated into the carbon pool, primarily in the lipids. Some of this carbon is excreted as carbon dioxide.¹¹² However, dextran does not appear to be converted into appreciable glucose in pancreatectomized dogs.¹¹³

An early report¹⁰⁹ noted a very low incidence of reactions (0.2%) in 25,000 infusions of dextran in Sweden. This has not been substantiated by more recent experience in which anaphylactoid reactions are common. Before changing to the use of the B-512 strain, there were 8% reactions to American dextran, 34% to Swedish dextran and 44% to British dextran.^{114, 115} There have been numerous clinical reports of reactions to dextran.¹¹⁶⁻¹²² This high incidence of reactions contrasts sharply with the statement of Thorsén in 1949 that he had observed a reaction rate of 0.4% with dextran as opposed to 8.2% with whole blood.¹²³ One possible explanation for this discrepancy is that the Swedish investigators did not report many of the minor types of reactions such as headache, chills, flushing, urticaria, wheezing,

angioneurotic edema, nausea, vomiting, cramps, chest pain, rhinitis, facial edema, joint pain, etc.,¹¹⁶ which are the major symptoms seen by more observant investigators. Actually the B-512 strain was adopted in an effort to reduce the frequency of reactions. The original dextran had 88% 1, 6 linkages, 5% 1, 4 and 7% 1, 3 while the B-512 dextran has 96% 1, 6 and 4% 1, 3. The lower degree of branching with B-512 is thought to have contributed to the reduction in the frequency of reactions.¹²² Similar reactions can be seen in animals. When rats are infused with dextran, swelling of the paws and generalized edema are observed. This is primarily mediated by 5HT although histamine is involved.¹²⁴ There is some cross protection between dextran and 48/80, an agent producing severe anaphylactoid reactions.¹²⁵ When rabbit blood cells are mixed in vitro with dextran, histamine is released and this release is proportional to the molecular weight and concentration of the dextran.¹²⁶ A recent investigation⁹ has demonstrated that dextran provokes a histamine release in the dog which is not accompanied by hypotension. This histamine release is quite small in magnitude when compared to that produced by acacia and PVP.

There has been some interest in the antigenicity of dextran. There is a reaction between dextran and leuconostoc antisera. Dextran also crossreacts with types 2, 12 and 20 antipneumococcal sera¹²⁷ and that from some salmonella and streptococci^{128, 129}. Dextran is a haptene in rabbits even when it is purified to a nitrogen content of less than 0.08%.¹³⁰ In man precipitins are formed and cutaneous sensitivity develops after the injection of 1 mg of a high molecular weight dextran.¹³¹ There are skin reactions to dextran in many persons who have not received dextran injections.¹³² Human sera from persons who have not received dextran frequently contains specific precipitins to dextran. The reaction rate to dextran is higher in those persons who have more than 2 microgm/ml of dextran-precipitable antibody nitrogen.¹²² Reactions are also more frequent among those who have the greatest increase in antibody nitrogen following inoculation.¹³³ The greater the proportion of non-1, 6 linkages to 1, 6 linkages the greater

is the formation of antibodies following injection. Thus the use of B-512 dextran is associated with lessened antigenicity.¹²² The molecular weight of dextran also contributes to the antigenicity and antibody formation which is greater with a fraction of 150,000 molecular weight as compared with a fraction of 30,000.¹³⁴ The significance of this antigenicity is difficult to determine. Dextran can precipitate plasma proteins and this observation tends to discredit results of antigenicity studies in which the quantity of nitrogen precipitable by dextran is measured. Undoubtedly high titers of antibodies may contribute significantly to a reaction to dextran. However, it is probable that there are few reactions to dextran caused entirely by antibodies. The reactions which are seen following dextran are probably the same type of anaphylactoid reactions seen with other colloids in which antibodies play little or no role.

Infusions of dextran do not decrease the concentrations of plasma constituents equally. Serum globulin and cholesterol are reduced more than albumin and this persists after the dilution is no longer apparent.^{135, 136} Dextran decreases fibrinogen concentration in excess of that expected by dilution. In dogs infused with dextran, fibrinogen decreases from 207 to 79 mg/100 ml in 15 minutes while albumin decreases from 2.81 to 1.33 Gm/100 ml.¹³⁷ Dextran also precipitates fibrinogen in vitro.¹³⁸ Dextran, acacia and PVP form insoluble complexes with fibrinogen at 4° C but not at 37° C¹³⁹ but the significance of this complex is not clear.

The effects of dextran on plasma proteins are important from another viewpoint. Dextran increases the ESR both in vitro and in vivo^{67, 72, 100}. Accompanying this increase in ESR there are minor difficulties encountered in blood typing.^{140, 142} The increased ESR is also associated with increased intravascular aggregation of blood elements.^{9, 61, 143} Swank¹⁴⁴ has shown that the injection of dextran in dogs causes aggregation of erythrocytes and slowing of blood flow by formation of amorphous films enveloping the cells. He relates the decrease in fibrinogen seen following dextran with the decrease in platelets and increased clumping of cells by suggesting that

a fibrinogen-dextran complex is formed which constitutes the film covering the cells and that this increases their adhesiveness.¹⁴⁴ He noted manifestations of neurological impairment in conscious dogs and suggests that this may also be due to a coating of the cells and endothelium with a fibrinogen-dextran complex decreasing the effective oxygenation.¹⁴⁴ The effects of dextran on the viscosity of the blood have also been related to this neurological deficit. Dextran increases the viscosity of blood in relation to its molecular weight. If the molecular weight is greater than 81,400, paralysis is noted. This is more closely related to increases in blood viscosity. The normal viscosity of blood is 4.5 centipoise. If this increases by 2.0 centipoise following dextran the dogs become paralyzed. If the increase is less than 1.4 centipoise there is no paralysis. Electrocardiographic indications of myocardial hypoxia occur with the paralysis and these revert to normal within one week. Swank suggests that this increase in blood viscosity may be extremely serious in certain patients, especially those with arteriosclerosis.¹⁴⁵ Thorsén and Hint in their extensive study of ESR noted that dextrans of molecular weight 59,000 and above produced increases in ESR.⁵³ However, the presence of low molecular weight dextran prevents or decreases the effects of the high molecular weight dextrans.⁵³ Hardwicke¹⁴⁶ has suggested that ESR is dependent upon the fibrinogen concentration and upon a serum factor. He notes that increased fibrinogen concentration will increase ESR and that fibrinogen levels are elevated in most conditions associated with increased ESR. He also noted the relation of dextran molecular weight to its effect.¹⁴⁷ This is consistent with the belief of Swank that the fibrinogen concentration at the surface of the erythrocyte is elevated by the deposition of a fibrinogen-dextran film. This concept is further supported by the observation that platelets suspended in protein solutions are coated with the proteins and that their isoelectric point shifts toward that of the protein. When dextran is added to such a mixture, there is a significant alteration in the mobility of the platelets and a decrease in their isoelectric point.¹⁴⁸

Weil and Webster¹⁴⁹ observed an increase

in the coagulation time of blood accompanied by a decrease in fibrinogen and platelets following addition of dextran to human blood in vitro. With large doses of dextran other investigators have reported prolongation of bleeding times which closely paralleled dextran levels.¹⁵⁰ In some patients there is hematuria in the absence of albuminuria.¹⁵¹ Adelson¹⁵² observed an increase in bleeding time in 46% of patients infused with one liter of dextran. The hemostatic defect is proportional to the molecular weight of the dextran and reaches its peak at 3 to 9 hours following the infusion. Clotting time is also prolonged by dextran and this is proportional to the molecular weight and the concentration of the dextran both in vitro and in vivo.¹⁵³ Adelson *et al*¹⁵⁴ have postulated that the increased bleeding time is a platelet effect. They found that thrombocytopenic dogs and patients are more sensitive to dextran and that the increase in bleeding time closely corresponds to the decrease in platelets. Dextran has been shown to inhibit threone activity which would tend to inhibit prothrombin activation.¹⁵⁵ Since threone is a combination of platelet clotting factors this evidence may support Adelson's belief. The most extensive study of the effect of dextran on the clotting mechanisms has been made by Jacobaeus.¹⁵⁶ He demonstrated that infusion of dextran reduces the prothrombin consumption in normal volunteers and that in several it was totally inhibited. This decrease in prothrombin consumption is greatest with the high molecular weight fractions and fractions with molecular weights of 41,000 are inactive. Fractions with low molecular weights actually increase the prothrombin consumption. As the molecular weight of the dextran is increased there is a decrease in platelet activity. Jacobaeus postulated that a platelet factor leaks out of the platelets and the higher molecular weight fraction causes faster leakage. The hemostatic defect is not seen until the supply in the platelets is exhausted or the leakage becomes too slow to make up for the inactivation of the factor free in the plasma. To explain the delay in appearance of the bleeding defect he postulated that the smaller molecules which increase prothrombin consumption prevent the

appearance of the prothrombin consumption inhibition by the larger molecules. The effect then becomes apparent when the smaller molecules are filtered and lost from the circulation. No bleeding defects were noted in 200,000 infusions of dextran early in its use. The original dextran was shorter and more branched than the modern B-512 and Jacobaeus has suggested that this change may have had some influence on the effect of dextran on the hemostatic mechanisms.¹⁵⁶

The major objections to the use of acacia and PVP are the storage phenomena and associated pathology occurring after their injection. It was believed that dextran would not exhibit these effects because its constituents were more closely related to the normal body components. Although the pathology associated with the injection of dextran is much less than that seen with the other colloids, tissue changes are not altogether absent. Following dextran administration in dogs and rabbits the epithelial cells of the tubules of the kidney are swollen, vacuolated and granular and the lumens of the tubules are filled with debris. This effect is transient, persisting less than 5 days.¹⁵⁷ In mice storage is marked in the liver, renal tubules and reticuloendothelial system.^{158, 159} In Korean casualties given dextran, its presence was marked in the spleen, myocardium and liver and the renal tubular cells were swollen and vacuolated resembling sucrose nephrosis.¹⁶⁰ These pathological findings are not very significant as there is little or no decrease in renal function following administration of large amounts of dextran.^{85, 97} Dextran is concentrated in the liver and lymph nodes but is converted fairly rapidly to glucose and utilized for energy with 6 to 25% excretion as carbon dioxide.^{161, 163} The more rapid metabolism of dextran may explain the transient changes associated with its storage in contrast to the permanent pathology which occurs with acacia and PVP.

The production of dextran in this country is rather limited considering its possible application. The total American civilian consumption in 1957 was 150,000 units. At that time the Federal Civil Defense Administration had 3,475,000 units stockpiled and the Department of Defense had about 1,400,000.¹⁶⁴

This stockpile would be entirely inadequate in a major disaster. The major limitation to more widespread use of dextran is its price. Dry bulk dextran costs \$13.00 per pound, but when this material is degraded, fractionated, tested, bottled, sterilized, transported and stored the wholesale price becomes \$6.50 to \$6.80 per unit of 500 ml of the 6% solution.¹⁶⁴

HYDRODEXTRAN

In an attempt to prevent reactions and hemostatic defects, Harrison *et al*¹⁶⁵ reduced the terminal aldehyde groups of dextran to primary alcohol groups. This product was called hydrodextran and was produced under the trade name of Hydrox by the J. T. Baker Company. It appears to be quite similar to unmodified dextran and 50% is excreted within 24 hours of administration to patients in shock. The plasma levels decline from 1860 mg/100 ml 30 minutes after the administration of one liter to 834 mg/100 ml at 24 hours.¹⁶⁵ There does not appear to be any benefit associated with this modification of dextran and as it involves the additional process of boron removal by ion exchange resins, it is probable that the increased cost would be prohibitive to widespread usage.

PLASMA

Although whole blood transfusions were attempted in 1818 and became frequent after Landsteiner discovered the ABO groups in 1900, plasma infusions were not widely used until 1932.²⁶ This is surprising as plasma fulfills most of the requirements of an ideal blood volume expander and is perhaps the most physiologically balanced colloidal solution for this use. It can be stored for long periods and can be used without crossmatching. Although 3% of the early plasma administrations were accompanied by allergic and thermal reactions¹⁶⁶ more recent work has emphasized the safety of plasma.¹⁶⁷ Serum hepatitis transmission can be prevented by storage of plasma at 76 to 96° F for 6 months. In contrast to a transmission rate of 1.9% in patients receiving blood, Allen has shown that hepatitis is not transmitted if patients receive plasma stored at room temperature for 6 months.^{167, 168} Plasma is not the final answer, however, and in addition to its limited supply and high cost

there are other disadvantages. If dogs are bled and maintained at blood pressures of 40 mm Hg for one hour, infusion of plasma will be followed by a loss of 40 to 50% of the infused volume within 30 minutes. This volume loss is accompanied by an equivalent loss of plasma proteins.¹⁶⁹ The reactions which follow administration of plasma are similar in many respects to reactions to whole blood and have been described by Nicholson.¹⁷⁰ Similar reactions can be seen in the dog. Autoinfusion of a dog's own plasma will result in expansion of plasma volume comparable to the amount infused, but administration of plasma from another dog will result in only 50% of the expected expansion. There is a concomitant loss of plasma proteins during this reaction and hypotension, urticaria and marked increases in gastric acid secretion have been observed.¹⁷¹ The hypotension, urticaria, edema, prolongation of bleeding time and liver congestion which accompany these infusions of plasma in dogs are lessened to some extent by anesthesia or antihistaminic drugs.¹⁷² This reactivity to plasma infusions may indicate that the dog is extremely sensitive to alterations of the normal colloidal balance of its blood and as such would be an excellent animal in which to survey the reactivity of parenteral colloidal solutions. Occasionally rapid infusion of citrated plasma or blood may be accompanied by toxic reactions related to hypocalcemia but these are rare and can be easily avoided by the simultaneous administration of calcium.^{173, 174} Fractions of the plasma proteins such as serum albumin have been used as blood volume expanders and seem to be quite useful. Their major disadvantage is that of plasma—limited availability and high cost.

MISCELLANEOUS BLOOD VOLUME EXPANDERS

The Russians seem to be especially active in the development of esoteric compounds for use as plasma substitutes. These include: (1) aminokrovin—an oxygen hydrolyzate of the residual blood clot after extraction of the serum of the erythrocytic mass after skimming off the plasma, of corpse blood or retroplacental blood; (2) polyglukin and syncol—

polyglucose and dextran respectively which have been noticed to cause hemostatic defects; (3) VK-8—an heterogenous protein solution devoid of antigenic properties; (4) L103—an incomplete acid hydrolyzate of animal blood; and (5) aminol—a fermentative hydrolyzate of animal blood.¹⁷⁵ Cadaver blood has been used in Russia since 1927. The formed elements remain viable for 5 hours post-mortem but the danger of bacterial contamination and toxin formation prevents widespread acceptance in this country.²⁰ Casein digests have been used in Europe with some success but a vasoconstrictor principle probably contributes to the effect. Subsido is a preparation of rutin developed in Germany which presumably decreases capillary permeability but is not a colloid and is probably no better than saline.²⁰ Gropper *et al*²⁰ also note that the use of okra, colloidal salts and amino acid polymers is being considered. Although these agents along with many others have the properties necessary for the expansion of blood volume, they are undoubtedly associated with a prohibitively high rate of reactions. Colloids which are similar to normal body constituents are probably the least toxic agents for parenteral use as blood volume expanders.

STARCH

Terashima¹⁷⁶ measured starch concentrations in blood by ethanol precipitation and acid hydrolysis following intravenous administration of soluble starch to rabbits. He found that the blood levels of starch decrease from 490 mg/100 ml 5 minutes after the injection of 1 Gm/kg to 7 mg/100 ml at 60 minutes. With glycogen 1 Gm/kg he noted a decrease from 1200 mg/100 ml at 5 minutes to 626 mg/100 ml at 1 hour, 439 mg/100 ml at 2 hours and 40 mg/100 ml at 12 hours. Excretion of glycogen in 24 hours amounted to 8% but no free sugar was found in the urine. Starch on the other hand was excreted to the extent of 5% of that infused in 20 hours and this was accompanied by the excretion of 11% as free glucose. Terashima also noted that the blood sugar level was elevated by 50 mg/100 ml following 1 Gm/kg of soluble starch and by 75 mg/100 ml following 1 Gm/kg of glycogen. The hyperglycemia persisted for about one

hour with starch and about 3 hours with glycogen.¹⁷⁶ This report would seem to indicate that starches are rapidly broken down when administered intravenously but that glycogen is more resistant to filtration. It also supports the concept that intravenous administration of polysaccharides can be utilized for parenteral alimentation.

Macromolecular polymers for parenteral use must be well dispersed in a colloidal solution. Intravenous injection of suspensions of ungelatinized starch in water produces pulmonary embolization and dyspnea. A recent study of the tolerance of dogs to infusions of macromolecular polymers has demonstrated that well-gelatinized starch solutions do not give rise to dyspnea or other manifestations of pulmonary embolization.⁹ These gelatinized preparations are well tolerated by dogs and anaphylactoid reactions to their injection are rare. Although reactions are uncommon, histamine release is observed following injection of small doses of starch and the magnitude of this release is equivalent to that seen with dextran.⁹ Injection of small doses of starch also produces thrombocytopenia which seems to be a characteristic effect of injections of all colloids.¹⁷⁷

Wiedersheim¹⁷⁸ has investigated the use of a corn starch with a molecular weight of 81,000 hydroxyethylated to a degree of substitution of 0.6. This starch, which he calls oxyethylstarch, is more soluble in water than native corn starch and is chemically inert, partly eliminated by the kidneys and does not cause allergic reactions. Rabbits which received 100 mg/kg of the oxyethylstarch daily for 3 months exhibited no pathological changes. When used as a 4% solution it restored the blood pressure of bled cats to control levels and even appeared superior to dextran in this regard.¹⁷⁸

A recent study¹⁷⁹ has shown that unsubstituted starch is rapidly eliminated from the circulation when administered to bled dogs. This rapid decline in blood concentration of starch is partially caused by the very high amylase activity of dog blood but this is not the predominant factor involved. Hydroxyethylation of starch to a degree of substitution of 0.6 afforded some degree of amylase

resistance and this type of starch was intermediate between dextran and unsubstituted starch in its rate of elimination.

PHYSIOCHEMICAL CONSIDERATIONS OF PLASMA SUBSTITUTES

The water-binding capacity of the colloid is of greatest interest. The amount of water actually bound by the serum proteins in a layer of hydration does not exceed 0.4 ml/Gm.¹⁸⁰ However it has been calculated that each gram of albumin actually holds 18 ml of water in the circulation. Two-thirds of this effect (12 ml) is due to the colloidal osmotic pressure exerted by albumin. The remaining 6 ml are held intravascularly by the Donnan effect of the charge on the proteins.¹⁸¹ This consideration clearly indicates the superiority of a charged polymer as compared with uncharged molecules such as dextran and starch.

Two other physical considerations are important in evaluating plasma substitutes. The colloidal osmotic pressure of the substitute should be in the same range as that of normal human serum which is 33 cm H₂O with a range of 28 to 48 cm H₂O.¹⁸⁰ It may be possible however to administer a more osmotically active concentrated solution in smaller volume with the expectation that fluid will be drawn into the circulatory system from the interstitial space. One of the limiting factors in the administration of colloids is their viscosity. The major hazard in administration of highly viscous solutions is the tendency to "overload" the circulation.

There has been little consideration of the development of plasma substitutes with different periods of circulatory retention for different applications. These colloids can be used in many ways: (1) to restore blood volume in oligemic shock when blood is not available, (2) to temporarily maintain a patient in shock until blood can be obtained, (3) to increase plasma volume in the hemoconcentration hypovolemia of burn shock, (4) to maintain colloidal osmotic pressure and prevent edema during cardiopulmonary bypass and the hypoproteinemia of starvation, liver disease, etc. (5) to produce tissue dehydration as in reduction of brain volume before neuro-

surgery, and (6) for parenteral alimentation. For each of these applications there is an optimum persistence of the colloid in the circulation.

The persistence of macromolecular polymers in the circulation depends upon the rate of degradation and the rate of filtration through capillary walls of the tissues and the kidney glomeruli. The molecular weight and spatial configuration of the polymer thus assume great importance and the number average molecular weight is probably more important since it corresponds more closely to osmotic pressure. The number average will change more rapidly than the weight average however since the smaller molecules will be excreted more rapidly. The range of molecular weight is also quite important as a sample with a range of 60,000 to 80,000 is grossly different from one with a range of 20,000 to 120,000.

It appears to be possible to produce starches with almost any degree of amylase resistance in any range of molecular weight distribution.

If this is true it would enable development of a series of solutions with almost any "half-life" in the circulation.

Campbell¹⁸⁰ notes that there are so many dynamic factors involved in determining the efficiency of plasma substitutes that it is impossible to predict the behavior of these colloids from their physical characteristics. This is quite unfortunate as it necessitates animal screening of a wide variety of products and no one type of screening procedure is adequate due to the multiple applications of these colloids.

In concluding, it might be pointed out that, with these polymers, the incidence of adverse effects is generally related to the dissimilarity between their chemical structure and that of normal body constituents. Dextran, a glucose polymer related to glycogen, is now the most commonly used plasma substitute. Starch is still closer in chemical similarity to body glycogen and a study of its derivatives is under way in these laboratories.

LIST OF REFERENCES

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| ABB | Arch. Biochem. & Biophys. | JPET | J. Pharmacol. & Exper. Therap. |
| AC | Analyt. Chem. | JPP | J. Pharm. & Pharmacol. |
| ACS | Acta chir. scandinav. | L | Lancet |
| AIM | A. M. A. Arch. Int. Med. | MADC | M. Ann. District of Columbia |
| AIP | Arch. internat. pharmacodyn. | MMW | München. med. Wechschr. |
| AJCP | Am. J. Clin. Path. | N | Nature, London |
| AJMS | Am. J. M. Sc. | NEJM | New England J. Med. |
| AJPa | Am. J. Path. | PRSM | Proc. Roy. Soc. Med. |
| AJPh | Am. J. Physiol. | PSEB | Proc. Soc. Exper. Biol. & Med. |
| AJS | Am. J. Surg. | QJEP | Quart. J. Exper. Physiol. |
| AMS | Acta med. scandinav. | S | Surgery |
| AnS | Ann. Surg. | SF | Surg. Forum |
| ANYA | Ann. New York Acad. Sc. | SGO | Surg. Gynec. & Obst. |
| AP | A. M. A. Arch. Path. | SMB | Stanford M. Bull. |
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MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA

ELECTROCARDIOGRAM OF THE MONTH

Sino-atrial block

DALE GROOM, M. D.
Department of Medicine

Case Record—This electrocardiogram was made at rest on a 71-year-old lady with a history of typical angina pectoris of about eight months duration. During that time she had been treated with digitalis and diuretics, apparently with some improvement in her dyspnea and occasional ankle edema. Her past medical history was notable only for questionable chorea in childhood and removal of both ovaries in early adult life.

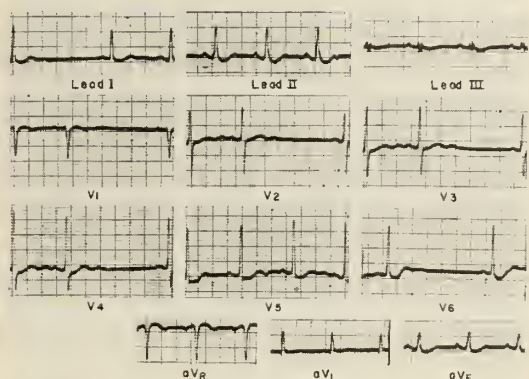
Her major complaint at this examination was that of an irregularity of her pulse. For several weeks she had been aware of a sensation of her heart stopping intermittently, associated with transient giddiness, then a disturbing and very forceful beat. These symptoms were thought to have been present prior to digitalization.

Electrocardiogram—Aside from a minimal sinus arrhythmia, the rhythm is basically a regular one at a rate of 90 which is punctuated by discrete pauses. These pauses during which time there is no sign of atrial activity are approximately double the regular cycle length in all instances. Long strips of tracing disclosed no constant sequence of repetition of the pauses, they occurring every minute or so at the time this electrocardiogram was made.

Careful measurement of the P-R intervals shows that they do vary slightly and in a repetitive pattern; always a little shorter (0.14) on the beat immediately following the pauses than on all other beats where they are 0.16 in length. Normal contour of the P waves throughout denotes their uniform origin from the sino-atrial node.

Additionally there are S-T depressions of 1 mm. in V_4 and V_5 , some T wave changes consistent with digitalis effect, and conspicuous U waves in several leads.

Discussion—Such momentary and usually recurrent interruptions of atrial activation have been divided into *sinus arrest*¹ in which the pauses are due to momentary failure of the SA node to initiate impulses, and *sino-atrial block* ascribed to intermittent failure of conduction of the normal impulses from the pacemaker node to the atria. In the latter case the pauses are necessarily multiples of the regular cycle length, as contrasted with the periods of sinus arrest which are of random length. Both produce similar symptoms the severity of which depend in large part upon the duration of the periods of asystole. A unique characteristic of sino-atrial block is the occasional doubling



or halving of the rate abruptly which is reported to take place with an intermittent (2:1) block of every alternate impulse.

Presumably a boundary exists across which the impulse must go from the SA node to the atrial muscle. If the threshold of the boundary is such that an occasional beat fails to leave the node, a dropped beat results in an otherwise regular rhythm. Quite possibly this phenomenon is analogous to the Wenckebach intervals of AV block, the threshold progressively rising to a critical level at which the impulse cannot escape from the pacemaking node, followed by a pause and then enhancement of conduction (note the shorter P-R intervals after each omission of a cycle). Whatever the mechanisms involved, sino-atrial block is considered by some to be more indicative of myocardial disease than simple sinus arrest which oftentimes amounts to little more than another variation (e.g., sinus arrhythmia, tachycardia, bradycardia, etc.) in the rate of impulse formation. However it should be noted that very long and doubtless sometimes fatal periods of asystole can occur with the sinus arrest caused by, for example, carotid sinus stimulation. The possible role of autonomic innervation in both types of atrial standstill is suggested by the frequent association of sinus arrhythmia with them. Electrolyte disorders, myocarditis and certain drugs, notably digitalis, have also been implicated. In this patient, with angina pectoris and S-T depressions consistent with ischemia, one might postulate a causal relationship between her coronary insufficiency and the sino-atrial block.

It is worthy of mention that the chief symptoms arising from brief interruptions in cardiac activity almost always pertain to the beat following the pause. This holds true in the common extrasystoles, in sinus pauses and, frequently, in atrial fibrillation. A reasonable explanation is that the familiar thump in the

chest is caused by an unusually forceful beat with a high stroke volume resulting from the prolonged period of ventricular filling.

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ACKNOWLEDGEMENT

I am indebted to Dr. Cheves Smythe of the Medical College of S. C. for submitting this interesting case.

POSTOPERATIVE COMPLICATIONS—III. ABDOMINAL WOUND DISRUPTION

R. RANDOLPH BRADHAM, M. D.

Department of Surgery

W. J. W. was an 81 year old white male admitted to the Medical College Hospital on June 4, 1960 with the chief complaint of abdominal pain and vomiting of 9 days duration. The abdomen was moderately distended and tympanitic especially in the upper quadrants. It appeared that the stomach was markedly distended. An upper gastrointestinal series on June 7 revealed moderate gastric outlet obstruction believed to be secondary to a benign process. The stomach was decompressed with continuous suction. Following this, milk in 200 ml. amounts was given and followed by aspiration of the stomach several hours later. This was continued for 3 days but repeatedly the amount aspirated was greater than the amount instilled. At the end of 6 days of conservative therapy, decision was made to relieve the obstruction by operation. A gastrojejunostomy combined with vagotomy was elected rather than subtotal gastrectomy as it was believed that the process was benign and that in the patient's weakened condition, the proposed procedure would be better tolerated.

This procedure was done on June 11. The obstruction was due to a cicatrix caused by an old peptic ulcer process. Oral fluids were given beginning on June 15. The following day there was moderate abdominal distention and hypoactive peristalsis. A moderate, persistent cough developed postoperatively. A roentgenogram of the abdomen with the patient in the supine position revealed reflex ileus. A lateral roentgenogram with the patient in the same position revealed gas filled small bowel extending to near the skin line. Because there appeared to be a small amount of fluid beneath the skin, the wound was examined. The anterior rectus sheath was found to be disrupted and a probe passed into the peritoneal cavity. Preparation was begun for operation immediately. At operation, it was found that the lower half of the operative wound was completely disrupted except for the skin. The anterior rectus sheath in the upper one half of the wound was also disrupted but the posterior sheath was intact. There was moderate distention of the stomach, small, and large bowel. A decompressing enterostomy was necessary. The abdomen was closed with large stainless steel wire retention sutures placed through the full thickness of the abdominal wall. The

patient had a relatively stormy postoperative course but eventually recovered.

Discussion

Incomplete wound disruptions often go unrecognized only to become manifest later as ventral hernias. The more serious wound disruptions are those in which the wound edges separate completely and the abdominal organs eviscerate. This occurrence in an elderly patient with a serious illness carries a high mortality, quoted anywhere from 20 to 70% in papers on this subject. The incidence of this complication has decreased with the numerous advances in surgical technique, antibiotics and supportive care.

Malnutrition, hypoproteinemia, chronic anemia, vitamin C deficiency, and constitutional disease predispose to wound disruption. Hypoproteinemia and vitamin C deficiency experimentally and clinically have been found to delay wound healing. All of these factors are rather difficult to assess. Many patients are operated upon with one or more of these factors existing at the time of operation and have no wound complication. Other patients experience wound disruption yet are known to have none of these predisposing factors. Certainly the patient who is in poor condition prior to, during, or following an operation will be more prone to poor wound healing. All factors predisposing to wound disruption should be corrected as well as possible, prior to operation.

Improper selection of suture material, defective suture technique, careless hemostasis, the occasional idiosyncrasy to absorbable material will compromise the competency of the wound. Wound disruptions occur, however, with every type of suture material and method of closure making it difficult to draw any conclusions as to the preferred suture material and technique of closing wounds.^{1, 2} Most clinics prefer a non-absorbable suture that causes minimal tissue reaction. When fascial layers are closed with interrupted stainless steel wire sutures, the wound is given maximum security.

Opinion in the literature is divided concerning infection in wounds predisposing to wound disruption. In one group of patients with this complication, 20 of 33 had wound infections,³ and in another group of 113 patients, 35% had a febrile postoperative course and 13% had a frank wound infection.²

What part drains and ostomies play in producing wound disruption has also been difficult to assess. Most investigators, however, have advised bringing drains and ostomies out through separate wounds.²⁻⁴ Evisceration of a wound incision with a colostomy is certainly more difficult to handle than evisceration without a colostomy.

Wound disruptions occur in every type of incision. Hartzell and Winfield³ in their collective review of 1,458 cases of wound disruption found that the greater number occurred in upper abdominal vertical incisions, particularly in the muscle-splitting type. In the majority of the surveys, this was the incision most commonly used, therefore, the most likely to disrupt on the basis of its most frequent use. In the upper

abdomen, the transverse incision preserves the nerve and blood supply, preserves the transversalis muscle, and gives a better purchase for sutures in the fascia with its transverse fibers. The lateral pull of the transverse and oblique muscles of the abdominal wall is avoided. It would seem to be the preferable incision to use in this location.

There is overall agreement that an increase in intra-abdominal pressure is the most important single factor relative to wound disruption. Retching, persistent coughing, unrelieved hiccoughs, habitual sneezing and distention are prime factors in disrupting even the most carefully closed wound. One or more of these factors occurring to an excessive degree was found in 75% of the cases reported by Tweedie and Long² and in 50% of those reported by Hartzell and Winfield.³ Every effort should be made to prevent and clear up any factor causing increased intra-abdominal pressure.

Suspicion that subcutaneous wound disruption has occurred warrants careful investigation of the incision, even to the extent of removing skin sutures to allow examination of the fascial layers. Intestinal obstruction, palpation of a loop of bowel under the skin, severe localized pain, and shock should dictate close scrutiny of the wound. Sudden, profuse, pink, serous drainage from a previously dry wound is virtually pathognomonic of wound disruption.

Once the diagnosis has been established, the patient should be intubated, and treated for shock should it exist. If an evisceration has occurred, the extruded viscera should be covered with sterile towels. With good relaxing anesthesia, viscera can be replaced and the wound can be secondarily closed with large retention sutures. Suture of the individual layers is often possible also.

Our patient exhibited many of the factors predisposing to and causing wound disruption. His body proteins and vitamin C levels were undoubtedly diminished during the 16 day period of relative starvation while he was obstructed. The postoperative cough and abdominal distention, although of short duration, were enough to increase his intra-abdominal pressure sufficiently to disrupt the wound. Fortunately, this was suspected and investigated early and the catastrophe of evisceration was aborted. In hindsight, this patient was an excellent candidate for retention sutures placed through the full thickness of the abdominal wall at the first operation. Retention sutures should be used prophylactically in such depleted patients.

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The presence of the artificial kidney at the Medical College Hospital and the activation of the Saul Alexander Research Unit has resulted in the referral of a number of patients with a wide variety of renal diseases to the Medical College Hospital. The editors of *The Journal* are instituting this series of clinics on medical aspects of various kidney diseases with the idea that some of the value of this concentration of experience might be shared with the readers of *The Journal*.

RENAL DISEASE

Azotemia secondary to electrolyte depletion induced by diuretics

CHEVES MCC. SMYTHE, M. D. & ROY HOWELL, M. D.
Department of Medicine

Enthusiastic use of the mercurial diuretics 15 years ago resulted in electrolyte depletion and azotemia on which attention was focused by Schroeder's paper on the low salt syndrome. The introduction and extensive use of the chlorthiazides in many clinical states has created clinical syndromes secondary to their potent effect on sodium, chloride and potassium excretion.

JMS, #25197, a 35 year old Negro male, was referred to the Medical College Hospital because of acutely progressive renal failure with oliguria.

The present illness began in 1943, 16 years before his admission to the hospital, with his rejection by the draft board for hypertension.

At the end of June, 1959, 6 weeks before his admission to the Medical College Hospital, while working in his fields on a hot day, he suddenly became dizzy and weak. His left arm became weak and numb. At the same time, he became short of breath and was unable to lie flat in bed. He lay at home for about 3 weeks and then was admitted to his county hospital on July 16, 1959. He was afebrile, had a sinus tachycardia of 120, and a blood pressure of 180/30 mm. Hg. He was a well developed, well nourished, chronically ill Negro man. His speech was slightly slurred, and he was not entirely clear mentally.

The eyegrounds revealed arteriolar narrowing with silver wire appearance of the arterioles. There was also nicking of the veins at the arteriolar venous crossings which is indicative of thickening of the arteriolar wall and chronicity of the hypertension. No hemorrhages or exudates were noted and there was no papilledema. The heart was enlarged 2 cm. to the left of the midclavicular line in the sixth intercostal space. Multiple premature ventricular contractions were heard. There were a few fine rales at both lung bases. There was minimal pretibial edema.

There was weakness of the left arm. No pathological reflexes were noted and no other neurological abnormalities were described.

His urine concentrated to 1.013 and contained a

trace of albumin. His white count was 24,000/eu. mm. with 90% polymorphonuclears. A blood non-protein nitrogen was 67 mg./100 ml. Phenosulphonphthalin excretion was 69% in two hours. Urine culture was negative. An electrocardiogram was consistent with left ventricular hypertrophy. A chest film showed left ventricular hypertrophy. Intravenous pyelograms were normal.

On admission to the hospital he was digitalized and given 2 ml. of Mereuhydrin. He was also started on chlorothiazide, 0.5 Gm. daily, Raudixin (Rauwolfia) 100 mg. daily, and a mixture of potassium salts containing 30 mEq daily. Seventy-two hours later he was feeling considerably better. His nausea had subsided and his mental condition cleared up. His blood pressure had fallen to 140/85. The blood non-protein nitrogen which had been 67 mg. or slightly elevated, fell to 39.5 mg. Despite these evidences of improvement, by his fifth hospital day the patient seemed to become weaker. His blood pressure remained in the neighborhood of 120/86. He then developed nausea and became apathetic, lethargic and weak. Two weeks after his admission to the hospital, he was not doing at all well. It was thought that this syndrome was due to sodium depletion and the chlorothiazide was discontinued. He next developed epigastric pain and flank pain with anorexia and nausea and vomiting. His blood pressure rose to 150/120. There were no objective findings in the abdomen. A lumbar puncture was negative. He then developed severe hiccups and increasing lethargy. He was transferred to the Medical College Hospital on August 5, 1959. His blood pressure at that time was 110/90.

His past history was not remarkable save for hypertension. He had no primary renal disease.

On physical examination on admission to the Medical College Hospital on August 5 he was a well developed, well nourished, slightly obtunded young Negro male in some distress from hiccups. His temperature was 99.8°F., pulse 95, respiration 24, and blood pressure 108/86. He weighed 162 pounds.

Physical examination was as previously described.

The initial impression was that this man had essential hypertension with a small infarct in his right cerebral hemisphere. His major problem seemed to be salt depletion secondary to the administration of chlorothiazide and sweating.

During his first night in the hospital he was given 2,000 ml. of 5% dextrose in normal saline intravenously. He was started on a 20 Gm. protein diet supplemented by 4 Gm. of sodium chloride per day orally. Hiccups were a severe problem, and he was given 25 mg. of Sparine (phenothiazine) by mouth four times daily for this and 5% CO₂ inhalations as needed. He was maintained on 0.1 Gm. of digitalis daily.

The initial urine concentrated to 1.009 and contained a trace of albumin and was otherwise clear. After he had received 2,000 ml. of normal saline or 18 Gm. of salt intravenously, his blood urea nitrogen was 28 mg., and his serum creatine was 4.6 mg. His

serum chlorides were 94.6 m Eq./liter and serum sodium 130.5 m Eq./liter. CO₂ combining power was normal at 60 vol. %, and the serum potassium was 4.72 m Eq./liter. On his admission to the hospital an electrocardiogram was remarkable only for premature ventricular contractions.

On his first day in the hospital his urinary output was 1400 ml. Thereafter, the urinary output remained satisfactory. His weight remained stable at 162 pounds. On institution of salt therapy, his blood pressure rose to the neighborhood of 130/90.

Over the next 4 or 5 days in the hospital, his mental state cleared. He regained body strength, his appetite increased, his hiccups subsided, and he generally felt much better. On his third hospital day, a kidney biopsy was done (Fig. 1) This showed hyalinization of the glomeruli, hyalinization of the arteries, with reduplication of the elastica, reduction in the size and lumens of the arterioles as well as some interstitial fibrosis. The section was consistent with arteriolar nephrosclerosis without malignant change.

At the end of 6 days in the hospital the patient was feeling well and was discharged.

Discussion

The clinical picture presented by this man is that of salt depletion. This was recognized by his physician and his referral to the Medical College Hospital was suggested because of better facilities for laboratory control of his condition.

There were probably two or three factors contributing to his salt depletion. First, he became ill while working in the sun. Secondly, he lay at home partially obtunded without anyone to care for him (his wife is in a mental hospital) for about two weeks. Presumably, he was sweating. On admission to the hospital he was given chlorothiazide. The outstanding characteristic of this diuretic is that it is extremely effective in potentiating the loss of sodium and chloride with subsequent loss of water by the distal and collecting tubules. Most individuals will not deplete themselves to a clinically hyponatremic state, but those with renal disease or extrarenal losses of salt will often do so.² The value of chlorothiazide as an antihypertensive agent lies in its ability to deplete body sodium stores with resultant decreased volume of blood in the arteriolar tree or changes in arteriolar vessel wall tone which are eventually followed by decreases in peripheral resistance and therefore, decreased blood pressure.

The clinical picture of low body sodium was first described by O'Shaughnessy³ during a London cholera epidemic in 1831. Recently, attention has been refocused on it under the name of the "low salt syndrome" by Schroeder.¹ Apathy, weakness, lethargy, progressing to stupor, abdominal discomfort with distention, occasional nausea and vomiting, decreased urinary output, and rising blood urea nitrogen constitutes the syndrome. In a carefully controlled study of subjects with renal disease, Nickel, *et al*⁴ demonstrated that depleting the body of sodium was ac-

accompanied by a decreased renal plasma flow, decreased glomerular filtration rate, and rising blood urea nitrogen. Repletion of these patient's sodium was attended by a return of all of these physiological parameters to normal.

Therefore, in the presence of renal disease or other conditions which cause an excessive drain of sodium from the body, the chlorothiazides should be administered to patients carefully. Their use is not contraindicated, but especially during the early stages of its administration, the patients should be followed

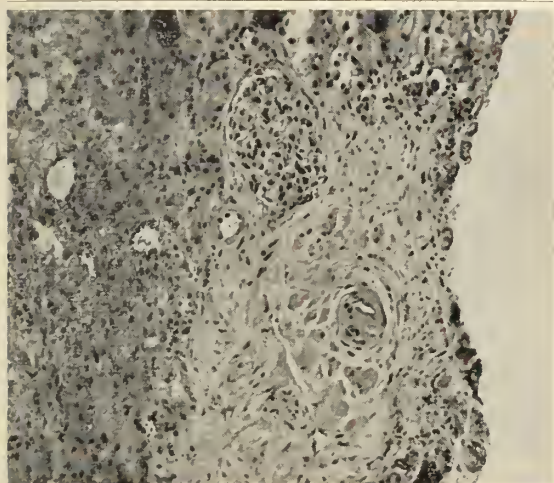


Fig. 1 x 150. Arteriolar nephrosclerosis. The small arteriole with its greatly thickened wall is the most striking change. This thickening is largely of the subintimal layers of the media. In addition, a lamellar change of the adventitia is apparent. There is an increased amount of fibrous interstitial tissue surrounding the arteriole. The glomerulus is not remarkable.

carefully with the idea in mind that unexpected symptoms might be due to excessive sodium or potassium losses. Weakness is characteristically the first of these.

The treatment of this condition is by sodium chloride. This can be given either intravenously or as salt tablets by mouth. Characteristically, these patients respond slowly and three or four days must go by before they are feeling well again. Careful calculation of the dosage of sodium chloride is not important in patients who are relatively well. In a patient such as this, the administration of 4 to 6 Gm. of sodium chloride in addition to what is taken orally will replete him at a satisfactory rate. This is usually given after a loading dose of 18 to 27 Gm. of salt.

The kidney biopsy in this patient revealed that his renal histology was completely consistent with hypertension as the etiology of his renal disease. There are no other conditions suggested and the illustration is quite typical of nephrosclerosis.

This man is now doing well. He has gained 30 pounds and is working full time with fair control of his hypertension with antihypertensive agents.

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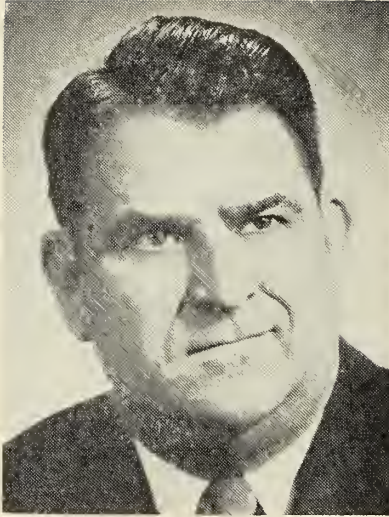
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A survey of the various attitudes in the relationship between psychiatry and religion. Norton Williams (Charleston) South. M. J. 973 (Aug.) 1960.

The purpose of this article was to survey the various attitudes and feelings that at present exist about the relationship between psychiatry and religion. The rapid growth of psychiatric theories and techniques has brought about an awareness on the part of many ministers that character change and character development are an integral part of psychiatric practice today. Mere symptom removal, although a very important part of the psychiatric work, is more clearly seen today as not a sufficiently high goal to be considered the full range of psychiatric work. This, of course, places psychiatric work astride the entire field of religion.

To those working ultimately and scrupulously in the fields of psychotherapy and psychoanalysis, the tremendous importance of some work with character change and development is obvious. This paper, therefore, is devoted to an attempt to delineate the role of both psychiatry and religion in this important phase of professional effort. The basic idea advanced is the part that organized religion can play in forming a setting that can substantiate and elaborate in everyday living what the psychotherapist or analyst does in the structural setting of his office work with the patient.

It is hoped that much further cooperative effort will continue in this new and growing field between psychiatry and religion.



President's Pages

Last month's President's Pages contained my remarks to the students of the Medical College on its opening day. The local newspapers printed portions of these remarks at the time and one of them commented editorially. A resume was sent out over the Associated Press and was published in several papers over the state. The publicity given these remarks emphasized the statements concerning high fees and socialized medicine and has caused certain reactions among those who read them. It is these reactions which prompt further comment from me this month concerning medical fees in particular.

First, came the comments from the doctors, some of whom resented the papers taking out of context the part pertaining to high medical fees and playing it up. They felt that the newspapers and the public themselves were not in a position to know what a high medical fee really was. Some felt that their fees were not high, particularly when taken in relation to charges by television repairmen, air-conditioning and heating contractors, plumbers, auto repairmen, and other trade technicians. Some were confident that their net income this year has been lower than it was five years ago, even though their gross might possibly be higher. High rentals and materials, increased wages and shorter hours for help, etc., has greatly increased their overhead.

These contentions have a great deal of merit.

Most medical fees are not out of line when compared with charges by people representing other vocations, when time required and expenses incurred for proper training is brought into its true perspective.

Most doctors do not overcharge. Undoubtedly, some do.

However, medical charges when combined with the increasing cost of drugs and hospitalization, whose charges seem to be in a continuous spiral, often reach a peak which spells catastrophe for many people.

Add to this existent evidence that indicates some few doctors do overcharge in fact, and that at times others will present bills which appear on the face to be out of line, and we have a situation ready made to create a feeling of intolerance toward all medical fees, with the doctor in the middle. Since he prescribes the medicine and orders the hospitalization the entire blame is often put on him. That this is so, is verified by the reaction of the general public to the newspaper publicity spoken of above.

Since that time I have traveled around the state, and have been amazed at the number of lay people who have sought me out at various meetings and told me how much they agreed with what the papers said. So many in fact, that I was convinced I should write on the same subject this month. All the doctors in our Association should know that the public is keenly cognizant of the high cost of medical care, and that they blame it on the doctors. Whether this is justified, or whether it is not, has no bearing on their attitude.

Hercin lies the crux of the problem.

The public does not understand all the various facets involved, and we HAVE NOT TAKEN THE TROUBLE TO DISCUSS THESE WITH THEM. There are a few people who are down on doctors along with everything else, and who will not listen to logic no matter how presented. However, the vast proportion of people are fair minded and will listen. It is up to us to persuade them that we are not greedy ogres who would keep them from getting proper medical care because of exorbitant cost, as many would have us believe.

In its public relations program, our Medical Association already has tried to present cer-

tain of these facts to the public through the newspapers, radio, and television. However much more needs to be done.

The public needs to be educated that medical expenses, even if they are high, can usually be insured against. We should not only let them know that insurance is available, but we should actively discuss the problem of prepaid medical care so that they might get all of the available information about Blue Cross and Blue Shield, and other reliable insurance plans that come to our attention.

I think that it would be in order for each physician to have in his outer office a sign which would state something like this:

"Are you adequately insured against medical expenses? This office will be glad to advise and consult with you concerning your insurance if you so desire."

A little interest on our part in our patients being properly insured will help them select adequate coverage and avoid keen disappointment after becoming ill when their policy does not cover their particular ailment, or has such small benefits as to be of practically no help.

We should make it a policy of discussing our fees with our patients before hand so that they will know approximately what to expect. If the service that they are to receive is of a particularly specialized nature, this should be explained also.

If they have insurance it should be understood in advance whether this insurance will be accepted as payment in full, or if additional payment will be necessary.

Those of us who use the patient's financial level as the yardstick as to what he will be charged, should be sure that the patient understands this way of thinking. Otherwise, discontent will arise because of different bills to patients for similar service. This usually comes out in the "gab fest" after the operation or illness, when one patient is trying to "out brag" the other.

I would recommend that each of us start a public relations campaign of our own, individually in our own office on our own patients. This should grow into an educational project at the local level, involving the Hospital Staff or County Society. We should let the people know the true facts concerning medical fees.

To help with this campaign I submit the following for your study. This article has also been sent to Mr. Tom Waring, Editor of the News and Courier.

This was in reply to a nationally syndicated column, appearing regularly in the Charlotte Observer, a financial column by Sylvia Porter. She wrote an article assailing the high cost of medical care and stated that it had increased during the past few years far above the normal increase in the cost of living. As a result of this article, a committee of physicians in Charlotte wrote to the paper and asked for permission to submit an article in rebuttal. The article follows:

In her column, dated January 12, entitled "Medical Costs Shocking" Sylvia Porter cited figures, apparently taken from context, which are incomplete.

When used in this manner they create an impression which is at times inaccurate and distorted. It is our desire to rectify some of the omissions — particularly with reference to physicians' fees.

The truth is, medical and hospital services — although they are unique in that they involve the lives and health of human beings — are nevertheless subject to the same economic pressures as other services and commodities.

They are not completely apart from the laws and workings of a free economy.

Concern over medical cost, if it is to be reasonable and logical, should be just one part of an overall concern regarding the inflationary trend of our entire economy.

This trend began around 1939 or 1940 and is continuing to this day. True, within that framework, hospital and other medical costs have risen.

The important question is how far and how fast have they gone up — in relation to the American people's income, purchasing power, and payments for other services and commodities?

According to the United States Department of Commerce, personal consumption ex-

penditures (this does not include public or governmental spending) totaled some 267 billion dollars in 1956.

Of this amount 32 per cent went for food and tobacco; 10.1 per cent for clothing and jewelry; 12 per cent for housing; 11.3 per cent for transportation. Only 4.5 went for total medical care. This includes physicians' services, hospitals, dentists' services, drugs and sundries, health insurance, and miscellaneous services, products and appliances.

When we examine the base period of 1935-1939, we find that the American people spent 4.1 per cent of all their personal expenditures on medical care. So percentage-wise, from that period to 1956, the increase was from 4.1 to 4.5 per cent.

In 1956 the 4.5 per cent of personal consumption expenditures which went for total medical care was divided up as follows: For physicians 1.22 per cent; for hospitals, 1.3 per cent; for drugs and sundries, 0.7 per cent; for dentists, 0.4 per cent; for all other, 0.9.

In 1955, the American people spent over \$13 billion on recreation — almost \$2 billion more than they did on all medical care that year.

They spent over \$9 billion on alcoholic beverages; this is almost 50 per cent more on alcohol than on physicians and hospitals combined.

They spent almost as much on tobacco as on physicians and hospitals together.

And they spent more on personal care — that is, toilet articles, barber shops, beauty parlors, and the like — than they did on either physicians or hospitals, taken separately.

These relationships between medical care and less essential commodities and services have existed for the past 25 years; together with the steady ratio between medical expenditures and all other consumer expenditures, they indicate a stability which could not exist if supply and demand were seriously out of balance in the field of medical services, or if the people had been subjected to excessive price rises.

Now, let's examine the behavior of medical prices.

Miss Porter states in her column that "general practitioners' fees have climbed 39 per cent . . . surgeon's fees have risen 26 per cent."

She also states that the cost of medical care has risen far more than the overall cost of living and that only the pace of the rise in transportation costs have topped the pace in the rise of medical expenses.

She continues, "the cost of medical care has gone up much more than the cost of food, housing, apparel, etc."

Concerning the fees of general practitioners and surgeons, our information (from the U. S. Bureau of Labor Statistics) shows that these fees lagged far behind the rise of the Consumer Price Index up until 1954.

The discrepancy is explained if Miss Porter used 1949-50 as her base period (160) rather than 1940.

Charts purporting to show that the cost of medical care has risen higher than the cost of living in the last decade appear, on closer scrutiny, to be something of an optical illusion.

In the 1950-57 chart, physicians' fees and medical care and drugs apparently rose higher than the consumer price index, taking the base period as 1947-49.

But the 1940-57 chart shows exactly the reverse: physicians' fees and medical costs are below the consumer index. (Using a base rate 1935-1939-100). Both charts show generally higher hospital costs.

It has also been calculated that 11 office calls cost a production worker a sum equal to one week's wages in 1935-39; in 1957 the same number of calls would have cost him only 49 per cent of one week's wages.

A recent study of the 1936-56 span published by the U. S. Bureau of Labor Statistics said: ". . . the price increase over the 20-year period was smaller for medical care other than hospitalization than for any one of the major groups."

It appears to us that physicians have followed rather than led in the rising price index.

Another way to gain perspective on the problem of medical costs is to look at the distribution of the medical dollar.

Ever since 1945 the percentage going for physicians' services has been declining, and the percentage going to hospitals has been increasing. Finally, in 1955, the hospitals' share passed the physicians' portion — 27.8 per cent for hospitals and 27.2 per cent for physicians. But the two together still make up only 55 per cent of all medical expenditures.

Drugs and sundries take 15.5 per cent; dentists' services nine per cent.

A fifth category — including such things as eyeglasses, orthopedic appliances, osteopaths and health insurance overhead costs — takes up 20.5 per cent.

This suggests that the question of controlling medical costs is not one problem but several — and with many subdivisions.

Moreover, it focuses attention on the fact that the major problem is hospital costs — not through any fault of the hospitals themselves, but rather because hospitals are being used more and more, because they are especially vulnerable to rising overhead costs, and because their price rises already have been much higher than average.

Still another factor in the picture is the distribution of medical expenses.

A 1953 survey by the Health Information Foundation showed that eight per cent of American families had no medical costs.

The vast majority of Americans in any year incur moderate medical expenses, but the distribution is uncertain.

A small proportion of individuals or families — either through one long, severe illness or because of a succession of illnesses — may encounter financial hardship, especially if they have been unwilling or unable to protect themselves by budgeting or by insurance.

To meet this problem of spotty, uneven distribution of medical expenses, the American people — as free agents in a free society — have adopted the mechanism of voluntary health insurance. Its growth and development over the past 25 years, and especially during the post-war years, have provided one of the brightest chapters in our economic history.

At the end of 1956, 112 million people had hospital insurance; 96 million were protected on surgical fees, and 63 million had medical fee coverage.

Most remarkable of all was the fact that in just the past five years the number of people with major medical expense coverage has increased one hundred times over — from 100,000 at the end of 1956.

Now a major insurance carrier is offering health insurance to persons over 65 years of age.

Recently the House of Delegates of the American Medical Association recommended to its members that they reduce fees for older people who have less than normal economic means.

We physicians are just as concerned about medical costs as anyone else, and we want to do all we can to keep them reasonable.

In medicine, every patient and every case is different. The patient is buying not only skill and knowledge, but also judgment, sympathy and understanding. You can't put a price tag on such things.

We appreciate very much the continued confidence of the people — our patients — and we renew our pledge to render the highest type service to them at reasonable cost.

When economic charges are leveled against us, however, we believe in all fairness that the full story, and not just part of it should be told.

I hope that all of us can take time to study the above article and fully digest all of its contents. Besides being very interesting, it is the most concise and informative article on this subject that I have run across. I believe the entire medical profession owes a debt of gratitude to Dr. David G. Welton, Dr. Paul G. Donner, and Dr. James E. Hemphill, of Charlotte, who prepared this article and had it published in their local paper.

Joseph P. Cain, Jr., M. D.

Editorials

NATIONAL MEDICAL ASSOCIATION

This *Journal* has never undertaken to comment on the matter of race relations, feeling that it was somewhat out of its province. Our Association opened its membership to Negro physicians some years ago, or at least certain component societies have included Negro physicians, and properly so. It may be that they would like to offer some comment on the subject that we mention here.

At a recent meeting of The National Medical Association (Negro) the organization went on record as supporting Forand-type "federal legislation . . . for medical care of the aged and aging." This was done largely at the instigation of its retiring president, and it appears that the incoming president is very much opposed to the stand taken. However, the proceedings are a matter of record, and until there is some denial, it must be assumed that the vote represents the majority opinion of the membership.

The American Medical Association has been so wholeheartedly opposed to Forand-type legislation, that it seems most undesirable that a segment of the physicians of the country should take officially and definitely a stand toward the opposite direction. It might be easily inferred that a persuasive orator might have swayed the Association into doing something which he interpreted as beneficial to the group of Negro physicians. It seems unfortunate that this splitting of sentiment should come at a time which seems very crucial in decision on such matters, for certainly the recent efforts now in abeyance by virtue of adjournment of Congress will be renewed later despite the substitute legislation which was passed.

While this action of the National Medical Association may be a blow for the benefit of the Negro in some fashion, it certainly is not to be considered as any assistance in the fight which a vast majority of physicians of the country are making to preserve the personal

relationship between doctor and patient and to avoid undesirable governmental control.

JOURNAL OFFICE LACKS OLD NUMBERS

With the various changes of editors and offices over the past years it seems that it has not been possible to maintain a complete file of this *Journal*, and the editor would like to appeal to anyone who has old issues earlier than 1950 to lend or donate them to *The Journal* for a reference file. Neither does the Association have a complete set of its *Transactions*. There is one particularly long gap from 1870 to 1888, and some of the other years are not in the best of condition. Any contributions along this line would be very much welcomed.

TELEVISION PROGRAM

Following the plan set up last year, the television program "House Call" has been continued for the past months and has enlisted the assistance of a considerable number of our members who have arranged or appeared on the panels. Columbia, Charleston and Greenville have had regular programs and occasional programs have been presented in Spartanburg and Florence.

The Association is very grateful to those members who have given their time and efforts to carrying out what the Association still believes is a very worthwhile effort to present Medicine to the public in an acceptable and productive form. Since our last report in *The Journal* of April 1960, the following members have participated.

Columbia, Station WIS: Drs. Donald Harwood, John Timmons, Charles Holmes, Benton Montgomery, Ben Miller, Waitus Tanner, Mr. James Daniels, Mr. W. A. Boyce and Mr. D. C. Dick.

Florence, Station WBTW: Drs. Julian Price,

W. R. Mead, J. P. Cain, Jr., W. L. Perry and Prentiss M. Kinney.

Greenville, Station WFBC: Drs. Robert Sumner, H. P. Jackson, A. G. Meakin. W. R. DeLoache, John Juller, Esley Jones, James McNamara, Peter Manos, Earle Furman, William E. Jett, Willis S. Hood, and W. M. Waters.

Charleston, Station WUSN: Drs. Alfred Rawl, Jr., Ely Brooks, F. M. Ball, Otis Pickett, J. J. Cleckley, Joseph Marshall, Junius M. Rowe, Arthur Williams, John Cuttino, T. G. Herbert, Kathleen Riley, Louis Jervey, Robert Walton, Fleetwood Hassell, Margaret Jenkins, Mr. Franklin Robson, Mr. Ray Everett, Mr. G. Searey, Mr. G. C. Moore.

Present plans, pending final approval by Council, are to continue the television shows to the end of this current year, and then to try to concentrate somewhat more actively on the speakers' activities. A number of scripts have been prepared and have been sent to many areas over the state, and this program which has been started will be continued, on a somewhat larger scale if possible. Some eighteen of our County Societies have indicated a willingness to recruit speakers and to obtain engagements for them before luncheon clubs, civic and community bodies of various sorts, to which they may interpret some of the current problems which concern the doctor and the public. There is still need for further participation in this activity, and the public relations office would be very glad to have replies to the letters sent some time back to all of the County Societies and to have the assurance that the program may be truly statewide.

The television shows which have been presented included the following subjects: Care of the Aged, Food Fadism, Medicine as a Career, Hospital Problems, Poisons in the Home, Hospitalization Insurance, Care and

Preservation of the American Business Man, and Mental Health. In addition, other subjects such as a program based on the South Carolina Legislative Committee Report on Problems of the Aging in South Carolina, and How to Reduce your Medical Costs, are in course of preparation.

The scripts which are furnished to the participants are merely suggestions and outlines, and there has been a good deal of necessary variation and addition at the time of actual presentation.

The same applies to the speeches which have been furnished. They are: Food Fadism, Rising Cost of Hospitalization, Care and Preservation of the American Businessman, Hidden Hazards, Poisons, Medicine as a Career, and Mental Health.

COFFEE BREAKFAST AND COFFEE BREAKS

There are those who like to start the day well fortified by a substantial amount of fuel derived from a good breakfast. There are others who gulp a cup of coffee and call it quits. The latter class has always seemed queer to one with a healthy appetite. Perhaps it counts on an early snack in the morning break which seems to be obligatory in most activities.

Studies of work capacity of people who have no breakfast but indulge in the midmorning break, providing miscellaneous food, indicate that the performance of these people is significantly less efficient than that of others who eat a conventional breakfast. Maybe this weakens the argument for the numerous breaks now considered essential by many workers. The time seems to be coming when the breaks will be for work rather than refreshment.

Please pass the ham and eggs.

BENEVOLENCE FUND

BENEVOLENCE FUNDS IN OTHER STATES

Dr. Beverly C. Smith, a distinguished surgeon of New York, has published a brochure covering information obtained by him concerning the establishment of benevolence funds by the various state medical associations and local organizations established for giving pecuniary aid to indigent physicians and their families.

This is titled, "A report on indigency among physicians and how it is handled in each state as reported by the executive secretaries of the societies of the 48 states and District of Columbia. By Beverly Chew Smith, New York City."

Indigency amongst physicians, their wives and widows is known by those administering the affairs of Physicians' Home in New York State to exist in this state to a greater degree than is known by the profession and the public. It is not only increasing, but economical and professional factors, which contribute to indigency, are becoming more active and obvious. Physicians' Home in New York State has currently helped as many as 60 applicants for beneficial aid in one year. We feel there are more than this number in the state whom we do not know of because they do not know of the Physicians' Home or are too proud to expose their indigency. The admission of financial failure seems to be more difficult in this professional group. After two attempts to establish a physical home had proven unpopular with guests, prohibitively expensive and eventually unsuccessful for very fundamental reasons, the idea was abandoned and the policy of sending a monthly stipend to the beneficiary—termed a guest—and allowing him to live where and with whom he chooses, was adopted by the board of directors. This policy has been successfully pursued since 1936. Having been intimately concerned with this problem in New York State for the past twenty years and having been cognizant of its increase, the author felt it might be constructive to know to what degree this situation exists in each of the other states. I, therefore, wrote the executive secretaries of each state medical society and the District of Columbia, asking whether the society recognized this problem, and, if so, what was being done to investigate and remedy it.

The results of this survey showed that there are 16 states that have established funds for this purpose. Thirty-two stated that no provisions had been made and one reported that the Women's Auxiliary provide the care necessary.

In adopting a plan for the establishment of a Benevolence Fund at its May 1960 meeting the South Carolina Medical Association became the 17th state to take this step.

In concluding this report of his study Dr. Smith stated in part as follows:

"On the basis of his experience in New York State, the author cannot in all cases accept the assertion that indigency or near indigency does not exist in

states that do not know of it, who have never investigated its existence. Doctors, their wives and widows are so proud that they have been found starving before admitting indigency. However, when financial aid is offered them, it is accepted with a heart-rendering gratitude. The author feels that there exists a state of near financial depletion in a number of instances amongst doctors which could be remedied by a small periodic gift or loan without interest. This study has brought forth violent expressions concerning "Social Security" for the medical profession, but these expressions were obviously made without understanding of the facts of this government agency. Finally, there will always be charity. The usefulness of the latter to obliterate or modify the former will depend upon investigation and wise administration."

BENEVOLENCE FUND

Directors

W. Atmar Smith, M. D.

O. B. Mayer, M. D.

Thomas G. Goldsmith, M. D.

Contributions

"Survivors", Class of 1910—Medical College of South Carolina \$ 50.00

Temporary Allotment, South Carolina Medical Association 500.00

\$550.00

Distribution to Beneficiaries 250.00

\$300.00

Approximate Balance

Beneficiaries — 2 Physicians

BIENNIAL REGISTRATION

Harold E. Jervcy, M. D.

There has been discussion since the annual meeting of the State Association concerning the wisdom of supporting legislation for biennial registration of physicians. There are those who maintain that they have heard no reasons presented as to the desirability or need for it. There are others who, while admitting to having heard it discussed, do not feel the arguments offered are sufficiently strong. For the benefit of all groups this brief article has been prepared.

In the fall of 1958, as secretary of the Board of Medical Examiners, I appeared before the Council of the state Association. I discussed all aspects of the proposal, answered the questions posed and requested that they support biennial registration. This they did without a dissenting vote. Later in the year, I appeared before the annual meeting of all county medical officers, discussed the idea and answered questions. A rough draft of the proposal was then presented to the Committee on Public Policy and Legislation. This committee passed it favorably and submitted it to the House of Delegates in May 1959. I appeared before the Reference Committee to which it was submitted, spoke for it, and answered questions. There was no other physician present who showed any

interest in the matter other than the committee. The House of Delegates passed the proposal in principle stipulating that a maximum fee of five dollars be placed in the proposal and requesting that the details be completed and presented for final action in 1960.

This year as you know it was resubmitted and once again was passed. Since 1958, the minutes of several of these meetings have been published in the *Journal of the South Carolina Medical Association*. Also, over this span of time, the individual board members and other interested doctors have discussed the proposal with many others over the state. It would not seem possible that there could be still some who have heard nothing about it or who have unanswered questions if they have made any effort to obtain the answers.

Before presenting specifics, I should like to present some of the considerations which led the board into adopting and actively supporting this legislation. For a number of years, the South Carolina Board had discussed the idea. In my activities with the Federation of State Medical Boards, I discussed the pros and cons with Board members from every state in the union. Subsequently, in my work with the AMA Disciplinary Committee and discussion with state medical society officers from all over the country my convictions were strengthened even more. There was complete unanimity in both groups as to the desirability and necessity for any board to have Registration if they were going to do their job properly and medicine was to police its own ranks. Even among the other Boards of South Carolina this has been found necessary to function properly. All felt that the most progressive legislation that they had enacted was registration and even though many had operated for years without it neither the men representing the state societies nor those representing the Boards could visualize any need for going back. At the beginning of the year, forty-two states had it. In talking to various members this year, at least two others have had it passed and the others are attempting to pass it. Sheer numbers is no argument for it, but the reasons that it has been adopted widely speak strongly for it. No state has adopted it without lengthy debate but once adopted even the opposition has been favorably impressed with the results. This I know, having talked with some of these men.

In presenting it in the manner that the South Carolina Board did, we attempted to avoid some of the errors made by other boards. Also, we have attempted to avoid a public fight and settle the disagreements within the confines of the medical profession. As you may not be aware, the Board of Medical Examiners is a department of state government. As such, it has the right and duty to recommend legislation at any time directly to the legislature which it believes is necessary for the fulfillment of its responsibilities or to protect the people of the state. This course could have been followed with resultant favorable or unfavorable action by the legislature in the session of 1959. However, as this particular legislation affected all physicians and to a nominal extent their pocket-

books, it was felt desirable to clear it through the state association and obtain their support. It was recognized that whereas unanimity was desirable it was far from realistic. Once it had cleared these channels, it was felt that the minority would follow the desires of the majority and a legislative fight and possible adverse newspaper publicity would be avoided. In many states in which this has been recently passed much favorable publicity was accorded the profession for recognizing their responsibilities and willingly supporting regimentation for the betterment of the profession and the public. If sufficient opposition is developed it will undoubtedly be to the detriment of the entire profession. Our disagreements should be kept within our own ranks which is what the Board has attempted to do. Much time and effort has been spent in attempting to familiarize all physicians of the State with the need for this action. This article is another effort in that direction.

There are approximately 140,000 members of the AMA. This represents the majority of physicians that have any contact with organized medicine and can be disciplined or kept in line through medical societies. On the other hand, there are 220,000 licensed physicians practicing medicine in this country. This is a conservative estimate. No accurate figure can be obtained unless all licensing boards have registration and can give an accurate count of those in its state. At any rate, there are 80,000 or more physicians who can only be kept track of and disciplined through the Boards of Medical Examiners. Any licensing board which does not know where its licensees are practicing and if they are practicing has a blind spot and cannot maintain its records or responsibilities to the people of its state or to organized medicine.

In South Carolina, the board has estimated through indirect methods that there are some 2,500 physicians holding licenses and in active practice. Once a license is granted, it remains in effect unless disciplinary action is brought or the individual dies. As a result, the South Carolina Board cannot give you an accurate figure of the number of physicians even practicing within the State of South Carolina. Neither can this be supplied by the Association headquarters. Only a highly intelligent guess can be made. In small areas of the state with a limited number of doctors there is little difficulty keeping up with the number present but in the more heavily populated sections, it is not quite so simple and in addition consideration has to be made for state and governmental agencies. And, as the state becomes more heavily industrialized, plant and union doctors will become a problem.

As a result of not knowing where the licensees are, the South Carolina Board is unable to exercise proper control. A physician may have disciplinary action brought in another state and then move back to South Carolina. This has probably happened on several occasions but it was caught on one occasion in recent years. In a like fashion, if the South Carolina Board disciplines a doctor and he moves out of the State, this information cannot be properly directed unless

there is registration and the Board can know where the physician is located. If all boards have registration, then all physicians can be kept up with, but as long as there are two or three which do not there will be a gap in the mechanism and to some degree will be likened to a fugitive going to another country.

It is not possible for a small state with limited funds and personnel to check on the disciplinary actions taken by all boards. If an alphabetical list of all licenses in effect were available, then it would be relatively simple. All boards have to work together in the area of medical discipline, not only to fulfill their own obligations, but obligation to medicine as a whole. Medical discipline especially in the light of the foreign medical graduate problem, will be brought more and more before the eye of the public. It is essential for the welfare of the profession and the people that they be made to realize that medicine is policing its own ranks and protecting the public from the unethical and disreputable. Registration is an important mechanism in the achievement of this goal.

Even if there were no additional reasons to be offered, the above should be adequate. As mentioned previously, estimates of from 1600 to 1800 physicians have been quoted in articles as practicing in the State of South Carolina. There are many groups who require such figures for papers and surveys being conducted. This encompasses such areas as statistical studies, conclusions on the need for additional medical school facilities based on physician-population ratio, and granting of federal funds for medical purposes rely on accurate figures. In addition, for sociological studies regarding movement of physicians, various scientific papers, and on the broad field of medicine such statistics as to why physicians move and to where are utilized. There are countless numbers of examples that could be given.

To the South Carolina Board, in addition to these, many request for information on licensees from legitimate sources are received. On many occasions information cannot be given because the board does not know the whereabouts of some licensees and does not have the staff to find out. This limits the service that we can perform and also makes it appear at times that we are grossly inefficient. Biennial registration would increase our efficiency in this area. There are many ramifications of the above which could be gone into but the main features as to why this legislation is necessary has been stated above.

Those who oppose this legislation have had only a few points to make. One is to the effect that this is merely a means for the board to raise additional funds. This is not so, but if it were, it would be a valid reason. The South Carolina Board operates on a budget of approximately \$7000 a year. At least one and possibly more of the county medical societies in this

state have a budget of this amount. Our scope of responsibility and activity far surpasses any county medical society. The South Carolina Board operates on one of the lowest budgets in the country. The highest is the California Board; the State of California appropriates \$400,000 plus per year for the operation of its board. At the present time, once a physician has been licensed in this state neither he nor the state government contributes one cent to the operation of the board. It would be highly desirable to have additional funds. Of more importance, the physicians of the state should recognize their responsibility in the proper regulation of medicine and be willing to contribute to the efficiency of operation. The \$5.00 every two years that has been stipulated will not contribute any additional operating revenue. It will probably take this to set up the files, conduct the correspondence, procure additional secretarial help, print a booklet listing all licensees and handle other expenses in this regard. It is highly unlikely that funds will evolve. The only reason that a medium of efficiency is maintained is that countless hours of service are rendered with no charge. The men of the board are dedicated to their jobs and the performance of their duties to the profession and to the people of the state. The profession as a whole should recognize their obligation and fulfill their responsibilities as is most fitting. The board only desires that physicians have an understanding of the problems and realize that the board is attempting to do its job in a fashion that will reflect credit on the entire profession.

In conclusion, I should say that the Board of Medical Examiners after much study and discussion does not feel that it can fulfill its responsibilities and operate efficiently without biennial registration.

SCHEDULE OF ACTIVE IMMUNIZATION FOR INFANTS AND CHILDREN

**RECOMMENDED BY THE COMMITTEE ON
CONTROL OF INFECTIOUS DISEASES OF
THE AMERICAN ACADEMY OF
PEDIATRICS**

AGE	PREPARATION
1½ - 2 months	D.P.T. Poliovaccine
3 months	D.P.T. Poliovaccine
4 months	D.P.T. Poliovaccine
10 - 12 months	Smallpox Vaccine
12 - 18 months	D.P.T. Poliovaccine
3 - 4 years	D.P.T. Poliovaccine
5 - 6 years	Smallpox Vaccine
8 years	D.T. (Adult type) Poliovaccine
12 years	D.T. (Adult type) Poliovaccine
16 years	D.T. (Adult type) Poliovaccine

MEDICAL COLLEGE OFFERS SYMPOSIA TO GROUPS IN THE STATE

The Medical College of South Carolina has been able to provide a modest budget for and is offering through its Continuation Education Program the following symposia:

1. The Present Day Management of Hypertension
Speakers: Cheves M. Smythe, M. D., Assistant Professor of Medicine.
Kenneth M. Lynch, Jr., M. D., Professor of Urology.
W. W. Vallotton, M. D., Associate Professor of Ophthalmology.
2. Strokes.
Speakers: Vince Moseley, M. D., Professor of Medicine.
O. Rhett Talbert, M. D., Assistant Professor of Neurology.
Harry W. Mims, M. D., Associate Professor of Rehabilitation and Physical Medicine.
3. The Menopause.
Speakers: J. Jennings Cleckley, M. D., Professor of Psychiatry.
E. J. Dennis, M. D., Assistant Professor of Obstetrics & Gynecology.
George C. Durst, M. D., Professor of General Practice.
4. The Use and Abuse of Antibiotics.
Speakers: Louis P. Jervy, M. D., Associate in Medicine.
Ben H. Boltjes, M. D., Professor of Microbiology.
Randolph Bradham, M. D., Assistant Professor of Surgery.
5. The Lymphomas.
Speakers: Charlton de Saussure, M. D., Assistant Professor of Medicine.
John C. Hawk, M. D., Associate Professor of Surgery.
Harold S. Pettit, M. D., Clinical Professor of Radiology.
6. What's New in Liver Disease.
Speakers: Forde A. McIver, M. D., Assistant Professor of Pathology.
Dan W. Ellis, M. D., Professor of Clinical Pathology.
Cheves M. Smythe, M. D., Assistant Professor of Medicine.
7. Thyroid Disease — Diagnosis and Treatment.
Speakers: John E. Buse, M. D., Assistant Professor of Medicine.
Maria G. Buse, M. D., Instructor in Chemistry.
R. Randolph Bradham, M. D., Assistant Professor of Surgery.
8. Recent Advances in Coronary Disease:
Speakers: Dale Groom, M. D., Assistant Professor of Medicine.
Edwin Boyle, M. D., Associate in Medicine.
J. M. Stallworth, M. D., Assistant Professor of Surgery.

These are designed as one-night circuit courses for presentation in various areas of the state during the year 1960-61. Each subject is prepared in advance by the three panelists plus a moderator, and presented as a panel discussion. The programs will be presented without charge. The suggested schedule is a 4:30 to 6:00 p. m. presentation, followed by refreshments, dutch dinner and a period for questions and answers.

The symposia are not primarily intended to provide program material for County medical meetings but rather as a new effort in post-graduate education in South Carolina, the continuation of which will depend upon the demand made for their use. The idea is to have the three or four speakers go to convenient places for local men to attend these with a minimum of loss of time from a busy practice. It is felt that this will encourage attendance by men who have difficulty in attending state wide meetings.

The American Academy of General Practice has approved each of these for three and one-half hours of Category I credit. This effort, if properly used, could therefore assist the membership drive of the Academy by making Category I credit courses more readily available to some potential members who have in the past had difficulty with this requirement.

Persons interested in these offerings should communicate with Dr. Dale Groom, Chairman of the Committee on Continuation Education of the Medical College. Arrangements can then be worked out as to time, place, attendance and program for presentation.

The Committee on Continuation Education wishes to encourage the physicians of the state to use the facilities of the Medical College for study. Special provisions can be made through the Chairman of this committee, Dr. Dale Groom, for any physician desiring to visit any departments or laboratories of the college for special studies or conferences.

News

MEDICAL COLLEGE EXPANSION

An approximately \$100,000 expansion project at the out-patient clinic of the Medical College Hospital has begun.

College officials awarded a contract for the work to Palmetto Construction Co. of Charleston.

A second stage of the out-patient clinic expansion program will include the ground floor of a million-dollar research building. The research center is still being designed but is expected to be in operation in about two years.

Other expansion plans at the South Carolina medical training and treatment center here include the psychiatric department. This program is estimated to cost about \$500,000.

The expansion is being financed with funds from the Hill-Burton federal program and college tuition revenue bonds.

S. C. A. G. P. NAMES NEW OFFICERS

The South Carolina Academy of General Practice named new officers at the annual meeting held in September. They are Dr. Jim Blanton of Chesnee, treasurer; Dr. Swift Black of Dillon, president-elect; Dr. Martin M. Teague of Laurens, president; Dr. Horace Whitworth of Greenville, vice president; and Dr. Bill Bannon of Simpsonville, secretary.

RURAL HEALTH CONFERENCE HEARS DR. PRICE

Dr. Julian P. Price, chairman of the board of trustees of the American Medical Association was among the speakers at the first regional conference on Rural Health in Atlanta October 7-8.

"Joining Hands for Community Health" was the theme of the 11-state meeting sponsored by AMA's Council on Rural Health.

The Annual Meeting of the South Carolina Orthopedic Association was held at the William Hilton Hotel at Hilton Head, South Carolina, September 16, 17, 18, 1960. The program included papers by Drs. David Holler, Thomas Edwards, David Riddle, Ritchie Belser, Hiram Kite, Emmett M. Luncford, Frank Stelling, Austin Moore, Francis Gay, James T. Green, and G. M. Gudmundson. Dr. William Boyd of Columbia was presented with a testimonial plaque indicating appreciation for his long membership and vital interest in orthopedics in South Carolina. Dr. Hiram Kite of Atlanta was guest speaker and was elected to honorary membership. Officers elected were: President, Dr. John A. Siegling of Charleston, Vice president, Dr. Frank Stelling of Greenville; and Secretary-Treasurer, Dr. James Green of Columbia. Dr. William Boyd of Columbia was elected President emeritus.

AMERICAN MEDICAL EDUCATION FOUNDATION

As a product of The South Carolina Plan the July 1960 issue of *The Foundation News* carries the following items.

Of the sixteen (16) awards of merit for 1959 to individuals for outstanding contributions to their medical schools through the A. M. E. F., eight (8) are to members of the faculty of the Medical College of South Carolina. They are Dr. Ben H. Boltjes, Professor of Microbiology, Dr. J. J. Cleckley, Professor of Psychiatry, Dr. Daniel W. Ellis, Professor of Clinical Pathology, Dr. Robert F. Hagerty, Associate Professor of Surgery, Dr. John E. Mahaffey, Assistant Professor of Anesthesiology, Dr. John H. Murdoch, Jr., Assistant Professor of Clinical Pathology, Dr. Harold S. Pettit, Professor of Radiology, and Dr. H. Rawling Pratt-Thomas, Professor of Pathology.

Also, listed as receiving the new A. M. E. F. Citation, awarded for the first time, are two other members of the faculty, Dr. Kenneth M. Lynch, now Chancellor and Dr. Vince Moseley, now Dean of Clinical Medicine and Professor of Medicine.

Among the organizations given *Awards of Merit* for 1959 is the Medical College of South Carolina Alumni Association.

J. Howard Stokes, M. D., Chairman, Florence
R. L. Crawford, M. D., Lancaster
Thomas R. Gaines, M. D., Anderson
Medical Education Foundation Committee
South Carolina Medical Association

AUGUST SCIENTIFIC MEETING OF THE COLUMBIA MEDICAL SOCIETY

The medical staff of the South Carolina State Hospital was host to the Columbia Medical Society for the Scientific Meeting on August 8, 1960. Dinner was served in the Benet Auditorium prior to the Scientific Program.

Dr. W. A. Hart, President of the Columbia Medical Society, presented Dr. William S. Hall, Superintendent of the South Carolina State Hospital, who spoke on "The Mental Health Act and the Private Practicing Physician".

With the aid of slides, Dr. Hall explained the new South Carolina Mental Health Act of 1952, which closely resembles the model Mental Health Act drafted by the National Institute for Mental Health.

He explained the five types of admission procedures and the necessity for physicians in private practice to understand each and the responsibility involved in the admission of a patient to a mental hospital.

The new Mental Health Act safeguards the rights of the patients; and represents a definite advance in the mental health field in South Carolina, Dr. Hall

explained. One important phase of the new act is the deletion of objectionable terms, and especially the substitution of the term "mentally ill."

Dr. Hall stressed the objectives of the South Carolina State Hospital and the responsibility resting upon the hospital to provide the best possible care for the mentally ill with maximum opportunities for prompt medical and mental care. The various ways for a patient to be separated from the hospital were explained. Dr. Hall also went into the new interstate compact which permits treatment of a mentally ill person in the indicated state on the basis of mental need and desired close proximity to family rather than enforced care in the state of residence.

TRIBUTE PAID TO DR. P. K. SWITZER, SR.

At a recent meeting held jointly by the Union County Medical Society and the Union Nurses Club, tribute was paid to Dr. Paul Kent Switzer, Sr., in recognition of his Golden Anniversary as a physician.

Dr. Harold P. Hope presented Dr. Switzer with an engraved silver cigarette chest on behalf of the Medical Society, and in words of appreciation attributed much of the success of the Society to the leadership, cooperation and wonderful example set by Dr. Switzer in his 50 years as a doctor. Gifts were also presented to Dr. Switzer by Dr. Francis P. Owings on behalf of the American Medical Association and Mrs. W. C. Bennett, president of the Nurses Club. Dr. Boyd L. Hames was Toastmaster for the occasion. Dr. Joseph H. Guess rendered the invocation.

Dr. Switzer was born in Switzer, S. C. in 1885 and graduated from the Medical College of the State of S. C. in 1910. After four years of practice in Fort Motte, S. C., he began his practice in Union in 1914.

Among the out-of-town Associate Members of the Union County Medical Society who attended the meeting were Drs. Charlton P. Armstrong, Jr. of Greenville; William A. Matthews of Rock Hill; Leslie C. Meyer of Greenville, William B. Ward of Rock Hill; and Theodore S. Wedde of Rock Hill.

DOCTOR WALKER OPENS OFFICE

Dr. Thurmond O. Walker has announced the opening of his office for the general practice of medicine at 1207 Sunset Blvd., West Columbia, in association with Dr. Richard W. Thomas.

Dr. Walker attended Columbia City schools and received a B.S. degree from the University of South Carolina in 1954. He graduated from the Medical College of South Carolina in 1958.

He did his rotating internship at the Columbia Hospital in 1958 and 1959. Since completing this he has been associated with the South Carolina State Hospital as staff physician.

DR. BRADFORD JOINS STAFF OF STATE HOSPITAL

Dr. Reese W. Bradford has assumed his position



"But, Doctor, I'm supposed to say 'A!'"

on the medical staff of the South Carolina State Hospital with assignment to the men's service, Columbia Unit, as announced by the hospital superintendent, Dr. William S. Hall.

A native of Georgia, Dr. Bradford attended the University of Georgia at Athens, and received his medical degree from the Medical College of Georgia, Augusta.

He recently retired as assistant superintendent of the Milledgeville State Hospital, Milledgeville, Ga., where he had been during his entire professional career.

SURGEON TO JOIN HOSPITAL

Beaufort Memorial Hospital next month will gain a staff surgeon when Dr. R. L. Redfield assumes his duties at the county medical center.

A native of Pleasantville, Pa., Dr. Redfield settled in Oil City shortly before World War II and pursued a successful medical career in that city until his move to Beaufort.

Well known in Pennsylvania medical circles, Dr. Redfield had been a member of the Oil City Hospital surgical staff since 1941 and its chief for many years. He is a member of the American College of Surgeons and the International College of Surgeons.

He is a graduate of Jefferson Medical College, Philadelphia, and interned at St. Vincent Hospital in Erie, Pa., before completing his surgical residency at the Millard Fillmore Hospital in Buffalo, N. Y.

DR. ROSENBERG IS PRESIDENT PIEDMONT CLINICAL GROUP

Abbeville's Dr. George V. Rosenberg is the new president of the Piedmont Post Graduate Clinical Assembly, succeeding Dr. John T. Davis of Wallhalla.

Dr. Rosenberg was named to the post at the recent 25th annual meeting at the Clemson House, which included a two-day series of lectures, discussions and banquets.

Other officers chosen were Dr. William Lummis,

Anderson, executive vice president; Dr. Frank Espey, Greenville, and Dr. Lewis Cacchiola, Hartwell, Ga., vice presidents; Dr. William H. Hunter, Clemson, registrar, and Dr. Ned Camp, Anderson, secretary-treasurer.

A native of Abbeville, Dr. Rosenberg graduated from Abbeville High School and The Citadel. He won his M. D. degree from the Medical College of South Carolina and interned at Roper Hospital, Charleston. He has served as president of the Abbeville County Medical Society and the Third District Medical Society, and is on the staffs of Abbeville County Memorial and Self Memorial Hospitals.

MULTIPLE SCLEROSIS MEETING

A statewide meeting to reorganize the South Carolina Multiple Sclerosis Society was held in Columbia on September 11.

Dr. W. H. Bridgers of Columbia spoke about the disease and its treatment. Dr. Rhett Talbert of the Charleston Medical College discussed research in the MS field. Emmett Carraher, regional director of the national society told of the need for volunteer workers.

Dr. Hugh W. Mole of Denmark is now registered and is a member of The American Board of Abdominal Surgery. Dr. Mole is a regular staff member of Bamberg County Memorial Hospital. He also practices in Orangeburg and Barnwell hospitals.

DR. DICKSON OPENS OFFICE

Dr. Griggs C. Dickson has opened an office for the practice of pediatric medicine in Hartsville. Offices are located at 807 Carolina Avenue, where he will be joined in November by Dr. James C. Parke, Jr., now completing a term of service as staff pediatrician at U. S. Naval Hospital, Portsmouth, Va.

Dr. Dickson is a native of Garner, N. C. He graduated from the University of North Carolina with the degree of B. S. in Medicine. In 1955 he received his M. D. degree from the University of North Carolina School of Medicine.

He served his internship at North Carolina Memorial Hospital in Chapel Hill in 1955-56 and his residency in pediatrics there in 1956-57. He was in the U. S. Navy during the period 1957-59, serving with the pediatric department of U. S. Naval Hospital at Portsmouth, Va.

From 1959 until the present, Dr. Dickson has been chief resident and instructor in the Department of Pediatrics at North Carolina Memorial Hospital.

The Seventh District Medical Association held a meeting at Kingstree on September 22, 1960. Speakers were Drs. John F. Buse, Jr., J. Manly Stallworth, H. R. Pratt-Thomas, and Clarence W. Legerton, all of Charleston.

The Coastal Medical Society held its meeting on September 22nd at Walterboro.

Announcements

ANNOUNCEMENT FOR GENERAL PRACTITIONERS AND INTERNISTS

Applications for Charter Membership in the American Society of Diagnostic Radiology are now being received. Membership is open to General Practitioners and Internists *who do or may desire to do some types of Diagnostic Radiology in their offices.*

For further information please write

Louis Shattuck Baer, M. D., F. A. C. P.
411 Primrose Road
Burlingame, Calif.

MEDICAL COLLEGE OF GEORGIA AND FOUNDATION PRESENT PROBLEMS OF THE NEWBORN INFANT

January 24, 25, 26, 1961

Registration is limited to a small group for close participant-faculty communication. Application form should be filled out and mailed, together with the fee, as soon as possible. Registration will be officially confirmed.

A block of rooms has been reserved at the Medical

Center Motel on Gwinnett Street across from Talmadge Hospital. Reservation cards will be sent direct to the registrants with a letter confirming acceptance to the course. Meals will be available in the immediate area.

Each course is acceptable for 18 hours credit, Category I, by the American Academy of General Practice.

A symposium on Clinical Nutrition will be held in Washington, D. C. on November 30, 1960. This symposium, sponsored by the Council on Foods and Nutrition of the American Medical Association in cooperation with The Medical Society of the District of Columbia, will begin at 8:30 a. m. Wednesday, November 30, in Room B of the National Guard Armory. The meeting will be opened to all interested persons.

There is a definite need for a general practitioner to locate in St. Stephen, South Carolina.

Since the death of Dr. T. B. Harper in that town, and the death of two physicians in surrounding communities, the patient load on the one general practitioner is entirely too heavy.

AMERICAN COLLEGE OF SURGEONS

Members of the medical profession are invited to attend an instructive three-day Sectional Meeting of the American College of Surgeons being held in Birmingham, Alabama, January 16, 17, 18, 1961.

ANNUAL REPORT OF THE CRIPPLED CHILDREN SOCIETY OF SOUTH CAROLINA, INC.

The Chairman of the Medical Advisory Committee to the Society has received a full report and wishes to pick out the more important and interesting points which it contains.

The Report begins with a brief history of the Society, now 25 years old and developing annually into greater activities. The chief objective of the Society is "To engage in activities to improve the health, welfare, education, rehabilitation, employment, recreation, facilities and opportunities of crippled children and adults of the State, regardless of race, color or creed." Twelve years ago the Society secured the assistance of the National Society of which it is a Chapter for professional guidance in making a state-wide survey in South Carolina in order to determine needs and to develop plans. Following this survey, it was decided that the efforts of the Society be concentrated on a state-wide cerebral palsy program which was to include not only actual service to patients but public educational activities, parent education, professional education and cooperation with other agencies concerned with the field of the crippled child. This program has included case findings, diagnostic and evaluation clinics, treatment centers, special committees to work with legislators and arrangements to work with the Vocational Rehabilitation Department. The survey showed that there would be an estimated 2,600 cerebral palsied children under the age of 21 in the state with 1,110 of this number in need of special services. The program has expanded to include a very large part of these potential patients and it is subjected to review periodically in order to bring it up to date.

Educational activities have been carried out through the press, radio, television, speakers' reports and miscellaneous literature. Conferences with parents are held very frequently and efforts toward improving the activities of professional workers have been unceasing.

The Society has interested itself in promoting special education of teachers who might handle special classes in the school and work with cerebral palsied and other handicapped children. Effective legislation to promote this activity may be traced very largely to the efforts of the Crippled Children Society and particularly of its efficient Executive Director, Mrs. Lowe.

The Society has also underwritten expenses of a speaker at the recent annual meetings of the South

Headquarters hotel for the meeting will be the Dinkler-Tutwiler.

The Columbia Medical Society will hold its Annual Meeting for the Election of Officers at the Hotel Columbia, Columbia, S. C., Monday, December 12, 1960, at 8:30 P. M.

Carolina Medical Association in order to keep the problem of cerebral palsy and its solution before the medical profession.

At the present the Society has a total of 440 cerebral palsied children and 38 adults on its active rolls for care in South Carolina. An additional 222 cases have been seen in the Easter Seal Clinics and been referred to other agencies whose facilities are more appropriate for their care. County Chapters have also provided funds to State tax-supported agencies to supplement services available to 586 cerebral palsied. The number here, added to the number on the active rolls of the Society would bring the total number of cases assisted by Easter Seal funds in South Carolina to 1,398. A State Easter Seal Cerebral Palsy Diagnostic and Evaluation Center with full staff is operated in Columbia. Greenville County has utilized its Easter Seal funds for setting up a Sheltered Workshop program. Other Easter Seal Centers are located in Charleston, Aiken, Greenwood, Rock Hill, and Spartanburg.

The Third Annual Easter Seal Family Camp was held in 1960. This provides camping activities for children who are too much handicapped to attend other camps and the opportunity for many counseling sessions with parents and various consultants.

Believing that basic research in the problem of cerebral palsy is essential to the progress of its program, the Society has given grants over the past several years to Dr. Isabel Lockard of the Medical College of South Carolina.

Believing also that there is a special necessity for training teachers in the conduct of special education for the handicapped child, the Society has made a grant of \$9,000 a year for a three-year period to the University of South Carolina for the establishment of a Chair of Special Education.

The financial report is impressive. The total amount spent for the fiscal year from the Easter Seal Campaign and special donations amounted to \$210,076.00. Incidentally, in the past two years the Easter Seal Funds have been expended for direct care and treatment services benefitting handicapped South Carolinians to the extent of \$419,596.00. In the five-year period past, almost \$125,000.00 has been expended for special education services for children with cerebral palsy and other crippling and handicapping conditions.

These brief remarks do not include all of the interesting and important material which is carried in the Annual Report of the Society. Many details and some

activities have been omitted. It is suggested that those who are interested in having the full story might write for a copy of the full report to Mrs. T. Jackson

Lowe, 1517 Laurel Street, Columbia, S. C.
J. I. Waring, Chairman

Book Reviews

DISEASES OF THE NEWBORN, by Alexander J. Schaffer, M. D. With a Section on Neonatal Cardiology by Milton Markowitz, M. D. W. B. Saunders Company: Philadelphia, 1960. Price \$20.00.

This is a large volume of more than eight hundred pages which covers in considerable detail the subject of diseases in the newborn. Except for the one section on neonatal cardiology by Markowitz, the book is entirely the work of the author, and is not a compilation or an edited collection. The subjects are well covered, and the exposition is well expressed. The author offers many case reports which are pertinent to the subjects under discussion, and many illustrations which point up the special matters in question.

The author is not categorical in his pronouncements, and frequently expresses a feeling that the subject under discussion is not a closed one and that his own view may not be entirely the correct one. Ample room for argument is left to the reader.

If after seeing this very worthwhile work, the reader should feel inclined to expand its ample size, it would of necessity be either repetitious or redundant. This book can be recommended without hesitation to anyone interested in that neonatal period which Dr. Schaffer calls the "last frontier of medicine."

JIW

FUNDAMENTALS OF CLINICAL HEMATOLOGY. By Byrd S. Leavell, M. D. and Oscar A. Thorup, M. D. 503 pages. W. B. Saunders Company, Philadelphia. 1960. Price \$10.00.

The need for a new text in hematology in view of the number already in existence is open to some question unless it fills a specific purpose or adds something heretofore not available. The authors of this book have attempted, therefore, to present the subject in a concise, brief, overall manner directed primarily to the third year student or busy general practitioner. Consequently a great deal of information is covered in a short space which allows only a cursory review of any particular topic.

The basic format is similar to other texts, starting with a review of the morphology, maturation, and metabolism of the blood cells. This is followed by a short survey of 1) various types of anemias, 2) blood coagulation, 3) diseases of the white cells, and 4) a final chapter of hematological techniques. Brief case reports are presented to illustrate the various syndromes which unfortunately cannot show the protean

manifestations of any of the disease states described and do not appear to add much to the overall value.

This book does have the advantage that it is up to date on many of the newer concepts in hematology such as the pathogenesis of various anemias, diagnostic techniques, and more recent modalities of therapy which are not included in older texts. It would seem to fill a limited need as a complete outline for students beginning clinical medicine and allowing them to get a general perspective. For a practitioner interested in a particular phase of hematology, however, it would appear to be too sketchy.

Charlton deSaussure, M. D.

REVIEW OF MEDICAL MICROBIOLOGY, by E. Jawetz, J. L. Melrick, and E. A. Adelberg. 4th Edition. Lange Medical Publications, Los Altos. 1960. pp. 377. Price \$5.00.

The authors' intention to write a book for the medical student and the practicing physician has been duly performed. The material of this Review is up to date and presented in a very clear cut and precise form. Anyone seeking information here should find it easily. The material in each chapter is presented in concise outline, which along with the clarity of the authors' writing, makes this an outstanding review.

It would seem to this reviewer that the allocation of only one chapter to the study of mycology is a grave injustice which should have been corrected before this 4th edition was published.

The bacterial and viral diseases are covered adequately. There is enough background material in the book for a good understanding of the principles or techniques involved. This review, as is true in all, suffers from the necessary omissions that are made. The omission of many important descriptions of colonial morphology on various cultural media is one of the reasons this book would not make a text for general microbiology as the authors have suggested.

J. Heyward Wynn, Jr.

RUDOLPH MATAS by Isadore Cohn, M. D. with Hermann B. Deutsch. Doubleday & Company, Inc., Garden City, N. Y., 1960. Price \$5.95.

Rudolph Matas, famous surgeon of New Orleans, died only a few years ago at the age of 97. At 80 years he was still performing surgery and his brilliant mind remained active until just immediately before his death.

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Research in the Service of Medicine



Born of a Spanish family, Dr. Matas was raised and educated in New Orleans, where he showed very early in life the evidences of the active part which he would play in Louisiana and world medicine. Before his graduation in medicine he served as an assistant to the commission under Dr. Sternberg and Dr. Chaillé which was sent to Cuba to try to determine the cause of yellow fever. Although the expedition was unsuccessful, the work done by Dr. Finlay on the transmission of the disease by the mosquito was to become the foundation of the final proof of the method of transmission. Dr. Finlay's announcement came out about two years after the commission had failed to find anything definite, and through an intimacy between Matas and Finlay, the former became the permanent champion of the real discoverer of the mosquito vector, and was to translate Finlay's first paper on the subject for publication in a *New Orleans Medical and Surgical Journal*.

Matas made enviable records in his medical school career and at the early age of 21 he became part owner and associate editor of the *New Orleans Medical and Surgical Journal*, at the same time building practice rapidly so that in time he became the foremost physician of New Orleans. There were intervals during which he deserted his practice to serve as yellow fever inspector at Vicksburg and to participate actively in a number of efforts.

Matas was in intimate friend of Lafcadio Hearn and they were inseparable companions for a time.

Matas soon became Demonstrator in Anatomy at Tulane and developed original views on the process in appendicitis. He likewise devised techniques for operation on aneurysm and might be considered as the father of blood vascular surgery. He was active in establishing the New Orleans Polyclinic (post-graduate school) and received world-wide recognition for his many contributions to surgical philosophy and technique; eventually he became Professor of Surgery at Tulane. In 1906 he lost one eye and from that time on he became the surgical artist rather than the originator of surgical manouvers. Honors came to him from many quarters. He was recognized abroad and attended many Congresses and received honorary degrees and awards in some number.

This book gives a review of medicine in New Orleans over a period of almost a century and paints an absorbing picture of the character and achievements of Dr. Matas. This reviewer found it most interesting, well written, and informative. There are parts of the book in which the subject seems to leave the stage almost entirely, and if any fault may be found it is in the touch of the same prolixity which the authors concede was a minor fault of Dr. Matas.

There are one or two oddments which were not quite explicable, such as the photograph of Dr. Matas' stillborn child, which seemed rather superfluous. The use of the term "Bronze John" for yellow fever was not familiar to the reviewer and he wondered whether this was a fancier term for the more familiar "Yellow Jack," or whether Yellow Jack

was actually a lineal descendant of Bronze John.

This book should furnish an ample amount of entertainment and instruction to any reader.

JW

HELP BRINGERS: VERSATILE PHYSICIANS OF NEW JERSEY, by Fred B. Rogers, M. D. Vantage Press, New York, 1960. Price \$2.95.

Dr. Rogers, Archivist of the Medical Society of New Jersey, has given us a book which contains a dozen sketches of prominent physicians of the state. Some of these vignettes have already appeared in the *Journal of the Medical Society of New Jersey*, others have been added to complete the lively and entertaining account. The subjects of the sketches cover the period from the very early days until practically the present moment and present a striking variety of characteristics. Of the older group, perhaps Nicholas Belleville was the most colorful, a Frenchman who had close contact with Count Pulaski, Joseph Bonaparte, Lafayette and the prominent physicians of the day of Philadelphia. Dr. Israel Clarke was best known as a wit, Dr. Abraham Coles as a poet and scholar, Dr. Newell for his activities in politics, Dr. English for his surviving poem "Ben Bolt", and others for their multitudinous activities in fields other than medicine. They are impressive because of their many interests, their many activities, and their contributions to the formation of the solid backbone of the medical profession of New Jersey.

The last three doctors represent medical contributions perhaps more realistically. Dr. Ezra Houek was a leader in public health, Dr. Cyrus Fogg Brackett was primarily a physicist and also a practitioner at times; his contributions in physics were recognized as most outstanding. Dr. Henry Leber Coit was a pioneer pediatrician who was firm in his advocacy of public health measures and effective in his effort to secure a proper milk supply. Certified milk was his chief and successful objective.

The articles included in this small book are well written, well presented and engaging in their quality. It is not necessary that one be a citizen of New Jersey to find entertainment and information in their pages.

JW

With an end in view. Sinai Hosp. J. 9:43-44, Spring 1960. Leon Banov, Jr. (Charleston)

Perhaps the most fundamental handicap in spreading knowledge of anorectal diseases has come about through a difficulty of language. Words often possess ambiguity of meaning. It is suggested that physicians who examine and treat the anorectum should strive to convey the precise meaning of what they wish to describe. By using correct and proper terminology, plus photography, the pace of progress, wherein diseases of the anorectum are concerned, will be accelerated. This is an end in view.

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AN ANALYSIS OF 300 CASES OF URINARY TRACT INFECTIONS

BUFORD S. CHAPPELL, M. D.

Columbia, S. C.

IT is not always easy to distinguish pyelonephritis from other infections of the urinary tract. Frequently the entire urinary tract is involved in the infectious process and the term "pan-urinary tract infection" would be preferable to "pyelonephritis" and would be more accurate and descriptive. A knowledge of urinary tract infections in general should provide an excellent basis for the study of pyelonephritis in particular. It is upon this supposition that we made our study of 300 cases. Here, as in pyelonephritis, many questions remain unanswered.

The best current studies of urinary tract infections originate in the larger medical centers. Here the patients are under excellent control, much better than could be expected in the patients under office control, with or without periodic hospitalization. These studies from the medical centers lack a great deal and do not present a true picture of urinary tract infections as seen in the day-to-day practice of medicine, or even urology. The patients seen and studied in the larger centers are usually seriously ill patients referred by general practitioners or specialists and who return home to this physician when they have improved and often will never be seen again at the medical center. In the medical centers, the free or clinic patients provide the best means for continuous long term observation and treatment, but they are cared for by the house staff, and house staffs change. On the other hand, the private practitioner with office control of his patients, should be able to provide important

The author presents a review of three hundred cases of urinary tract infections, pointing out that they occur most often in the young sexually active female or the woman in the early menopausal state. This type of infection presents some difficulty in treatment. In 64% there is some association with abnormalities of the urinary tract.

supplementary information. He has the opportunity to see and follow the seriously ill and the less seriously ill patient, often for years. He should be able to gain important information regarding recurrences, effectiveness of therapy and the progress and course of the disease in general. It is in this attitude that we presume to present our analysis, realizing that our series is too small for statistical evaluation, but hoping that some interesting trends will be uncovered.

The Study

Three hundred unselected cases of urinary tract infections, out of several times this number, seen and followed in my office during the past ten years were analyzed. The cases were analyzed as they came to hand and none was rejected because of lack of completeness of data, but in an effort to keep the analysis as accurate as possible, only so much data as was specifically stated was removed from the chart. The final tabulation took into account only the positive data available. In an effort to answer the question as to whether there has occurred an appreciable change in urinary tract in-

fections within the past five years, the cases were divided into those seen for the first time during the years 1950-1954 (100 cases) and those seen for the first time during the years 1955-1959 (200 cases). The cases were analyzed under thirty headings and many sub-headings and the data accumulated into 24 tables. Since it would be impractical to publish all of this material, only the salient features have been selected for publication.

Results

The age at which urinary tract infections are most apt to occur is early adulthood, reaching a peak at 20-25 years and with a secondary peak at 41-45 years of age. The infections were found to occur more than twice as frequently in the female (70:30). There seemed to be no correlation between race, marital status, number of children, occupation and the occurrence of the infection. Symptoms had been present in 37% for one week or less, in 19% for longer than a year and in almost 2%, for most of their lives. Of the symptoms referable to urination, dysuria was most common, 44%; frequency was second, 33%; and surprisingly, hematuria was third with 28%. Flank pain, 31% and discomfort in the bladder region, 25%, were the most common localizing symptoms. Fever had been present in 19% of those applying for treatment. Similar episodes had occurred in 65% and of these 32% had been treated by the family physician, 20% by other urologists, 20% by other physicians and 28% did not have the specialty of the physician listed or saw no physician. Previous hospitalization had taken place in 20% of all the patients studied, 17% had had previous cystoscopy and 16% previous pyelography. Only 48% appeared to be ill and only 19% had tenderness over the flanks in spite of the presence of pyelophritis in nearly 50% of the cases. There was considerable variation in the findings of the first urinalysis: 46% showed a cloudy urine, 48% showed albumin, 28% showed over 100 pus cells per high powered microscopic field and 36% showed microscopic hematuria.

Seventy-one percent were hospitalized during the course of their observation and treatment, while 29% were seen in the office only. One hundred ninety-nine cystoscopies were

done and of these, 49 were normal, even though the patient was diagnosed as having a urinary tract infection. One hundred and seven retrograde pyelograms were done and of these, 51 were normal. One hundred eighty-seven intravenous pyelograms were done with 85 normal. The ratio of number done to normal was practically the same for intravenous and retrograde pyelography. In 66 patients, cystoscopies, retrograde pyelograms and intravenous pyelograms were done. Fifteen of the 72 patients not admitted to the hospital were subjected to x-ray study on the out-patient basis.

Cystitis was found in 73 cases: 28 were acute (including 21 cases of acute hemorrhagic cystitis), 27 were chronic and 18 cases were recurrent. Three cases of cystitis cystica and one case of irradiation ulcer of the bladder were observed. One hundred and twenty (40%) had lower urinary tract infections and of this number, one-half were cysto-urethritis in the female. One hundred twenty-nine cases (43%) of pyelonephritis were found in the 300 cases studied. Fifty-two were acute, 51 were chronic and 38 were recurrent (12 of the acute or chronic cases were also included with the ones listed as recurrent). Of 114 cases so studied, 45 were unilateral, 69 were bilateral, 80 occurred in association with some other disease of the urinary tract, but 34 had no such known association. Eight cases of pyonephrosis, one case of carbuncle of the kidney and one case of abscess of the kidney were not included with the cases of pyelonephritis. Of the 80 cases with associated lesions of the genito-urinary tract, 23 or almost 30% had calculi. Twenty-two had associated infections in the bladder and lower urinary tract. Only eight cases of the 199 cystoscopies had post cystoscopic febrile reactions.

Only 108 cases (36%) were treated by drugs alone; 122 or 41% were treated by drugs and manipulations; 70 or 23% required surgery. Two hundred and forty-one cases were evaluated as to the effectiveness of the drug therapy, and in 5% no drug was effective, in 30% the initial drug was effective throughout, in 35% the initial drug lost its effectiveness and had to be changed, in 20% the drug was changed by choice, usually because the pa-

tient was allergic or could not take the drug; in 10% the initial drug was not effective from the first. Dilation of the urethra was carried out in 90 cases, usually in females with chronic cicatricial urethritis; nephrectomy was performed in 10 cases; nephrolithotomy was done in 8 cases; cystoscopic removal of ureteral calculi in 10 cases; ureterolithotomy in 3 cases and bilateral ureterolithotomy in one case; plastic surgery was performed on the kidney in 2 cases and on a solitary kidney in 2 other cases; abscesses drained, carbuncle excised and cysts excised in 1 case each; and other miscellaneous procedures were carried out to total 70 operations and 122 manipulative procedures for a total of 192—or almost two-thirds of the entire series.

Twenty percent showed clearing of the infection in one week, 58% had cleared at the end of one month, 72% had cleared at the end of three months, 8% required longer than three months and 20% never cleared. Recurrences were frequent: 15% suffered at least one recurrence, 7% suffered two and 11% suffered more than three recurrences. Ninety-three cases (31%) had recurrences with 4% recurring within the first ten days (10% of those suffering recurrences) 7% within the first month (23% of those with recurrences) 18% (55% of those with recurrences) within the first six months, and 8% (25% of recurrent cases) had the first recurrence more than a year after the initial attack seen by the author. Only 19% required less than one month of treatment, 58% required less than one year of treatment and 36% required more than one year of treatment; 6% are still under active treatment and 11% required more than 5 years of treatment, although intermittent in character.

The results of the treatment showed an apparent cure for 45%; loss of contact with patient in 15%; went to another urologist in 2%; back with family doctor in 4%; not under treatment but poor response in 4%; under treatment but poor response in 3%; under active therapy 6%; recurrent 14%; under control but not cured in 16%; died from infection of genito-urinary tract, none; died from other urological disease, 2 persons (less than 1%);

died from other causes, 4 patients, a little more than 1%.

Discussion

In our opening statement, we discredited the statistical value of this study and the percentile values have been given only in an effort to establish the overall picture and particularly the nature and course of urinary tract infections controlled over a long period of time by the same observer. Because of the lack of acknowledged statistical value, we make no reference to other statistical studies. We believe the study to present many interesting features. Although the cases were divided into two groups, 1950-1954 and 1955-1959, those occurring in the last five year group behaved in essentially the same manner as the earlier group. As a matter of fact, the second group responded a little more readily, perhaps as a result of improved anti-bacterial therapy and a tendency on our part to keep the patient under treatment for longer periods of time, but the time under observation has been shorter.

It would seem that the highest incidence of urinary tract infection is in the young female in the active childbearing and sexual age. The second highest incidence occurred in the early climacteric. Sexual activity and childbearing undoubtedly play major roles in the younger age group, whereas no positive reason can be given for the occurrence of the rather high peak in the 41-45 year old group, except for early menopause and perhaps a high percentage of pelvic surgery in this group. The 28% incidence of hematuria in this series, I believe to be of great interest. It must be remembered that this was a subjective symptom and microscopic hematuria was found in 36% in the first urinalysis. The first indication of the recurrent nature of urinary tract infections is realized when it was found that 65% had suffered previous similar episodes and that urologists had seen only about one-fifth of the patients previously. The family physician had seen and treated the largest number, as would be expected. I was impressed with the fact that less than one-half of the patients appeared ill. Symptoms referable to urination were quite common, but localizing symptoms and general symptoms were very few. The patients simply did not appear to be ill.

As a urologist, I have long been interested in the differential diagnosis of urinary tract infections. In our series, 71% were hospitalized; 199 had cystoscopic examination, with 49 of them normal; 107 had retrograde pyelograms, with 51 normal; 187 had intravenous pyelograms and 85 were normal. These studies were done on patients with proven urinary tract infections, and yet in many there were no significant findings on cystoscopy or pyelography. Although the diagnosis of pyelonephritis was made in 129 cases, cystitis in 73 cases and lower urinary tract infection in 120 cases, cystitis was found associated with pyelonephritis in only 22 cases. Very definite pyelonephritis was often found associated with what appeared to be a normal bladder on cystoscopy. I believe that the percentage of pyelonephritis cases diagnosed in this series is probably too small. The presence of pus in the urine is taken by some physicians as sufficient evidence for the diagnosis of pyelonephritis. Strictly speaking, the diagnosis of pyelonephritis cannot be made unless infected urine has been obtained from the kidneys by catheter. Most cystoscopies are, at present, done under anesthesia, especially thiopental (Pentothal) anesthesia, and because of suppression of renal function, a kidney specimen is not obtained. At other times the urine from the kidney is so bloody as to be of little value on microscopic study. The diagnosis of pyelonephritis then frequently depends on the presence of rather severe general symptoms of infection, such as high fever, chills, leucocytosis and localizing symptoms such as pain over the costovertebral angles. The presence of pyelographic findings, such as obstruction (23 cases had associated calculi) can be of a great deal of help.

I believe that albuminuria can be of real value as an aid in the differentiation of upper and lower urinary tract infection. It has been an observation of mine that even in the presence of considerable blood and pus in the urine from a lower urinary tract infection, there is not much albuminuria, whereas, if the pyuria and hematuria is of renal origin, the albuminuria is much more pronounced. Only 48% of our cases showed any albuminuria at all. The diagnosis of chronic pyelonephritis is

more difficult and requires considerable skill, especially in interpreting pyelographic evidence of scarring and blunting of calices and bizarre caliceal patterns that result from the scarring of old long-standing pyelonephritis. Blunting of the calices was found only in 20 cases on retrograde, and in 12 cases on intravenous pyelography in this series. Bizarre caliceal patterns suggestive of chronic infection was found in 8 instances on retrograde pyelography and in 5 instances on intravenous pyelography. The presence of pus casts in the urine is pathognomonic of pyelonephritis.

The status of the urologist in the treatment of urinary tract infections is immediately apparent when it is seen that 64% required some form of manipulation or surgery (23% required surgery), and that of 114 cases of pyelonephritis considered, 80% had associated genito-urinary tract disease. All successful therapy must depend upon accurate diagnosis, and in the urinary tract such diagnosis often depends upon the urologist. Thirty-six percent of the cases depended upon drug therapy alone, although all cases were subjected to chemotherapy or antibiotics. The six most effective drugs were found to be, in order: Furadantin, Achromycin, Chloromycetin, Gantrisin, Mandelamine and Thiosulfil. These drugs were found to be about equally effective, whether administered blindly or as a result of sensitivity tests, although admittedly, only 44 cases were treated in strict conformity with sensitivity tests. It was a very common observation that the "mycin" drugs were often life-saving in the severe infections, but that Furadantin or the sulfonamides frequently had to be used to effect the final clearing of the urine and for long-term therapy. Mandelamine is not the drug of choice for the impatient therapist, for it usually requires long administration and is a particularly useful drug in long-term therapy. Frequently after all medication has failed, the patient can be placed on Mandelamine for several months and then tried on some of the "mycin" drugs or other chemotherapeutic agents with excellent results. At times, it is even desirable to take the patient off all medication for several months and then the formerly ineffective therapeutic agents may prove effective. This

requires more courage than we usually possess. The figures for the length of time under treatment, demonstrate the fact that many of the patients were kept under prolonged observation after the urine had cleared. Patience is a necessity in the handling of urinary tract infections when it is realized that 42% of our patients required more than one month to clear, and 8% required longer than three months and 20% never cleared. In less than one-half of our patients (46%) did we effect what we consider a "cure". In spite of this, we had no deaths in the series attributable even remotely to infection. Most of the patients have remained active and apparently healthy and productive individuals, although many have suffered from the disease for years.

Summary

As the result of a study of a small series of 300 urinary tract infections, and reducing the statistical data to indicate trends rather than a basis for comparison with other series, we found that urinary tract infections were most apt to occur in the young sexually active

female and the early menopausal woman. We found also that usually the patient had suffered many previous episodes, commonly over a period of many years or months, and that less than one-half appeared acutely or chronically ill; that the disease was very difficult to treat and required many weeks of treatment to effect a clearing of the urine and even then there was a great tendency for recurrence. Less than half of the urinary tract infections could be proven to have associated pyelonephritis, and it was shown that pyelonephritis could occur without cystitis or lower urinary tract infection, but the vast majority of cases (64%) of pyelonephritis had some associated disease of the genito-urinary tract and that many required urological (not including cystoscopy) manipulation or surgery. Although we could effect what could be called a "cure" in less than one-half of the cases treated, almost all the patients remained active and productive and there were no deaths from infection.

We believe the study of urinary tract infections in general an excellent basis for consideration of pyelonephritis in particular.

Myasthenia gravis in a southern community by Milton Alter, O. Rhett Talbert, and L. T. Kurland. (Charleston) Arch. Neurol. 3:399-403, Oct. 1960.

Thirteen cases of myasthenia gravis which had occurred among residents of Charleston County, S. C., were ascertained after reviewing hospital records for the ten year period 1946 through 1955, surveying the experience of practitioners in the community, examining mortality data, and soliciting information from public health nurses and lay health organizations. The average annual incidence of myasthenia gravis was 0.55 cases per 100,000 population. The prevalence of this disease on January 1, 1956, was 3.2 per 100,000 population.

The median age of onset for all cases was 25.5 years. Only 6 of the 13 patients were alive in 1958; one case was in remission. The median duration of illness before death for six of the seven patients that died before January 1, 1958, was three years, with a median age at death of 30 years. Thymoma had not been diagnosed in any of the cases. No familial aggregates were encountered. There was no indication of an appreciable prevalence difference between the white and Negro populations of Charleston.

Comparison of the results in Charleston with those of three other communities similarly studied gives the impression that myasthenia gravis has a uniform low

prevalence, but epidemiologic information is still insufficient to discern a definite pattern of geographical distribution.

It is suggested that additional community surveys might disclose areas which differ significantly in the occurrence of myasthenia gravis and that further study of these areas might lead to a better understanding of causative factors.

O. R. T.

The camera in proctology, Leon Banov, Jr. (Charleston) South. M. J. 53:1081, Sept. 1960.

This report brings into focus some of the difficulties of communication in proctology in the past, and spotlights a way to promote progress in proctology in the future. Today, cameras are available which are technically easy to use so any physician can photograph anorectal lesions. Since words are inadequate to describe an anorectal lesion, photographs improve the clarity and accuracy of the transmission of ideas. By improving the medium of communication, progress in the study and treatment of diseases of the anorectum can be accelerated. To increase the dissemination of accurate information the camera should be standard equipment for the modern physician who treats anorectal diseases.

CONGENITAL ARTERIOVENOUS ANEURYSMS

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Arteriovenous aneurysms (arteriovenous fistulae) are not extreme surgical rarities. However, most of these are of the acquired variety following gunshot wounds, stab wounds, crush injuries, operative procedures, degenerative or infective changes, et cetera. A search of the literature for purely congenital arteriovenous fistulae results in discovery of probably less than 250 cases. One can get an idea of the relative frequency of the congenital and acquired varieties from the report of Callander,¹ who reviewed the literature in 1920 and came up with 447 cases of arteriovenous fistulae, only 3 of which were congenital.

The first description of a congenital arteriovenous aneurysm is credited to Hewitt, in 1867. A large percentage of cases reported since that time have been single case reports, emphasizing the limited experience of any one individual in the field.

Congenital arteriovenous aneurysms may be quite small and involve a limited area of skin and subcutaneous tissue, or they may involve an entire extremity or even half the

The authors present a discussion of a relatively rare condition and give a case report in detail.

body. Probably the lower extremities account for the greatest percentage of involvement, followed by the upper extremities, and the head and neck regions. Involved in a considerable number of cases are the lungs, brain and kidneys. The congenital arteriovenous fistula is usually a mass of dilated, elongated, intercommunicating arteries and veins. The vascular shunts are usually multiple. (This is a contrast with the acquired varieties which frequently have a single arteriovenous communication.) The larger arteries tend to undergo thrombosis and revascularization by many thin walled vessels. A rather heavy fibroblastic reaction accompanies this process. The process tends to spread peripherally from the edge of the lesion into the otherwise normal surrounding tissues. Apparently, no organs, including bones, are spared. Arteriovenous fistula bears a very close relationship to the



Fig. I

The left buttock was larger than the right, and the lesion measured some 7 cm. in diameter, was purplish red in appearance, pulsated, was warm to the touch, and exhibited a biphasic bruit.

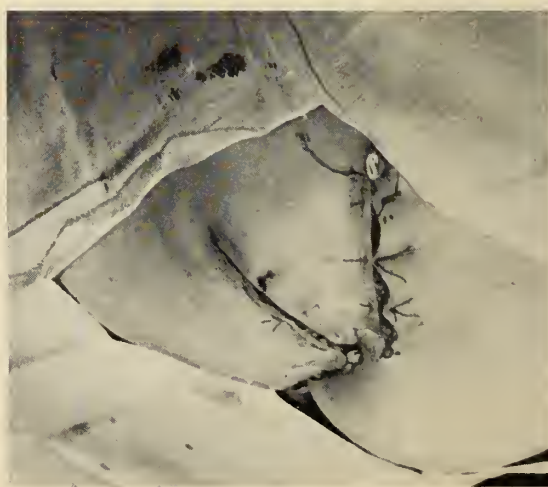


Fig. II

The incision chosen was dictated by the geography of the lesion, a desire to control the major blood supply at an early point in the operation, and a desire for a primary closure of the resulting wound.

ordinary angioma and the dividing line between the two remains a moot question. Crosse, et al,³ conclude that congenital arteriovenous aneurysms may represent persistence of portions of undifferentiated vascular loops found in the early embryo, and that the angioma may represent persistence of the venous side of the loop.

The local and systemic effects of these vascular short-cuts are well known and include the following; cardiac volume increases, often in association with dilatation and hypertrophy of the left ventricle, and cardiac decompensation. The pulse pressure tends to



Fig. III

Showing the tumor mass excised, along with its overlying skin.

widen. The lesion itself reveals a loud continuous roaring murmur and a palpable thrill. The area of the lesion is often hotter than the normal skin and may exhibit hypertrophy. Skin ulceration or bony erosion may occur. Branham's sign may be present. Severe cases may result in gangrene of an extremity.

Diagnosis depends largely on history and physical findings, aided by angiograms. Cineangiography would seem to be an excellent addition to this armamentarium.

The recent advances in vascular surgery have not been reflected in the treatment of arteriovenous aneurysms. No definite pattern of their treatment has evolved, largely due to their own lack of uniformity and the in-

accessibility of many of them. Unfortunately, permanent cure is often associated with mutilation or loss of limb. Of 30 cases reported by Lewis,² surgical excision was attempted in 19, and resultant amputation became necessary in 11.

At present it is generally agreed that resection of the mass of arteriovenous communications (instead of merely ligating its major feeding vessels) is a prerequisite for adequate treatment.

Case Report

The subject of our report is a ten and a half year old white female with a presenting complaint of a mass in the left buttock. Her mother stated that she had noted a bluish red discoloration of the buttocks when the baby was carried home from the hospital. The lesion seemed to grow geographically in about the same proportion as the child grew. However, the left side of the buttocks gradually became larger than the right. The mother stated that when she picked the child up, the left side of the buttocks always seemed hotter than the other side. She could recall no episodes of ulceration and could also recall that the patient had slid down her sliding board on numerous occasions without untoward results.

When the child was approximately 8 years old, the lesion was subjected to a series of five x-ray treatments, after which her physician noted some improvement. However, some months later the lesion was progressing and surgical consultation was requested.

Initial examination revealed a well-developed and nourished school girl with a blood pressure of 110/70 mm. Hg., pulse 80, and essentially negative findings except for the left gluteal region. The left buttock was considerably larger than the right and the skin exhibited an area of purplish red discoloration some 7 cm. in diameter. This area partially covered a pulsating mass, which exhibited a biphasic bruit. Initial impression was that an arteriovenous aneurysm was present, probably involving the superior gluteal artery and associated veins.

The method of treatment chosen was ligation of the feeding vessels, along with excision of the numerous vascular channels. The lesion was found to arise from the inferior gluteal vessels, which were approximately 4 to 5 times their normal size. The tumor mass which was removed consisted of a small portion of the gluteus maximus muscle, a large amount of subcutaneous tissue and the overlying skin. The wound was closed primarily and the postoperative course was uneventful except for some minimal and expected infection.

Pathological report is as follows: The vessels in the subcutaneous tissue are very large and have relatively thin muscular coats. In the adjacent tissue there are innumerable dilated capillaries. Some large vessels have thin muscular coats and their appearance is con-

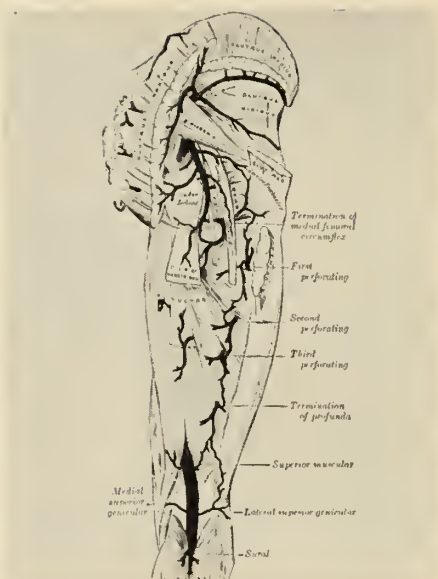


Fig. IV

Showing the anatomy of the gluteal region with special reference to the inferior gluteal artery. (From Gray's Anatomy).

sistent with markedly dilated veins. The appearance is compatible with the diagnosis of arteriovenous aneurysm.

The patient is now six months postoperative. The skin incision is healed and intact. There is no evidence of recurrence of the aneurysm. The general condition of the patient remains good.

Summary

A brief discussion of congenital arteriovenous aneurysms is offered and their relative rarity is recalled. A case is presented which involved a ten year old white female in which the aneurysm was excised in toto along with its feeding vessels.

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THE AGING

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The town gossip was rolling the sweet morsel under her tongue that Mr. Soanso was chasing after another woman. Mrs. Soanso listened patiently and unperturbed, then said, "I know my husband isn't interested in any other woman—he's too true, he's too fine, he's too good, he's too old!"

I don't know how old a fellow has to be to fall into that category, but I do know there are an estimated 150,000 persons in South Carolina who are 65 years of age and over, and what's better than that, something's being done about them.

South Carolina is following the national pattern which is working toward a White House Conference on the Problems of the Aging in 1961. The Governor has appointed a Committee to study these problems, consisting of Senators Wilbur G. Grant of Chester, John D. Long of Union, Representatives Martha Thomas Fitzgerald of Columbia and T. Edmond Garrison of Anderson as the legislative

members and Dr. Wil Lou Gray of Columbia, Mr. O. T. Wallace of Charleston and Miss Nell Watson of Easley as Appointees at large. Mrs. Fitzgerald is the very able chairman of this committee.

These appointed members began their work by enlisting personnel from the departments of Health, Education and Welfare in each County to be the nucleus of county committees. They, in turn asked interested citizens to join with them in this good project.

First, the County Committees made surveys of the situation as it pertains to the aging in their own counties. Then the State Office compiled these findings into a State report to be sent to Washington. The state report was also studied by the combined county committees meeting together in Columbia. Our President, Dr. Joe Cain presided over the medical section. At present the recommendations that came out of that meeting are being edited.

South Carolina has made a good start on

studying the problems of the Aging and the prognosis for a good state program is splendid.

Several basic principles are already becoming evident. May I list a few of them?

1. We are studying problems of the "Aging" instead of the "Aged" because the latter includes only a small, indefinite group of "other people" while the former term includes all of us.
2. We are opposed to having government do for any group or individual what that group or individual, or the local community, can do for itself.
3. So far, we feel that mandatory retirement at a given chronological age is probably unfair to many individuals.
4. The percentage of "the aging" in our population is rapidly increasing and their problems are increasing proportionately.

Progress is being made on other fronts too, as health insurance coverage for people past 65 is being expanded steadily thru the efforts of many Blue Cross-Blue Shield plans and also by commercial insurance companies.

The age limits of the State and national study are perhaps a little surprising, since they include all persons 45 years of age or over, with special emphasis on the 65 and over group.

Someone has said that Middle Age is so called because that's where it shows. Many of us who are "approaching" middle-age like to

keep in mind this prayer written by J. F. and quoted here:

Lord, as Thou knowest better than I, in the sight of men I am weathering and some day will be old. Protect me from loquacity and particularly from the fatal habit of thinking that I must say something on every subject, and on every occasion. Release me from the craving to straighten out everybody's affairs.

Make me thoughtful but not moody, helpful but not bossy. With my vast store of wisdom it seems a pity not to use it all, but Thou knowest, Lord, that I need a few remaining friends at the end.

Keep my mind airborne and free from those dusty trails of endless detail. Give me wings to get to the point. Seal my lips on my aches and pains; they are becoming sweeter as these years go by. I dare not ask for grace sufficient to enjoy the talcs of others' pains, but help me to endure them with patience.

Teach me the glorious lesson that occasionally I *may* be mistaken.

Keep me reasonably sweet; I do not want to be a saint (some of them are so hard to live with) but a sour old man or woman is a crowning work of the Devil.

Grant that I may extract all of the possible mirth out of life—there are so many hilarious things in life—and I don't want to miss any of them. Amen.

GRISEOFULVIN AND FUNGUS INFECTION

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This paper will deal with the new antibiotic griseofulvin and its use in treating fungus infections. In addition to a summary of the work of others, our experience in treating over 100 cases in the past ten months will be presented.*

Like the discovery of *Penicillium notatum*, isolated in 1928 by Sir Alexander Fleming, but not fully recognized for its antibiotic qualities until 1938, *Penicillium griseofulvin* was isolated in 1939 but not fully recognized for its antifungal properties for nearly twenty years.¹ It was first used in agriculture and after trying it topically with only fair results, Peterkin was about to begin its experimental evaluation by mouth when he stopped because of laboratory evidence in animals suggesting damage to the seminal epithelium.² However, apparently simultaneously and independently Blank in this country, Riehl in Vienna and Williams in London began to use the drug successfully in patients in the fall of 1958.³ The drug has been marketed in this country for approximately nine months.

Griseofulvin is a fermentation product of three species of penicillium, *P. patulum*, *P. griseofulvin*, and *P. janczewski* and its chemical structure has been established. It is a white powder, poorly soluble in water, withstands autoclaving and is relatively stable in the dry form. It is fungistatic rather than fungicidal and produces a "curling" or damaging effect causing a spiral-like distortion of the hyphae. All studies show excellent inhibition of all the dermatophytic fungi both by in vitro and in vivo studies and so far there has been no proven in vivo resistance. It has apparently no effect against bacteria and the deep fungi. (North American blastomycosis, histoplasmosis, etc.), but some favorable results have been obtained with intermediate fungi causing Madura foot and in sporo-

trichosis.⁴ It is not effective against *candida albicans* (monilias) nor is it effective against tinea versicolor, that ubiquitous and bothersome fungus infection frequently called "white spot disease" or *acromia parasitica*.

Extensive toxicological studies including routine blood and urine examinations, bone marrow, liver and kidney function studies, sperm counts, testicular biopsy, electrocardiographic, electroencephalographic and pathological studies have all, so far, shown no damage, except in Pipkin's series.⁵ He reported white blood cell depression with the range of counts dropping to 4000/cu. mm. in 20% of a series of 51 patients. All of these had a return to normal after stopping the drug and no serious trouble was encountered.⁶ No other such reports have been made despite extensive and widespread worldwide studies. Only occasional urticarial or toxic eruptions, headaches, or gastro-intestinal disturbances have been reported, although I have had one patient who developed vesiculo-papular lesions and later hyperpigmentation and exfoliation from one manufacturer's product and not from another. In addition, if this patient took more than two tablets a day, she would develop symptoms of weakness, sweating and impending collapse. At present, studies are being made to determine the exact cause of this reaction. Another patient has on two occasions, experienced fever, malaise, weakness and gastro-intestinal disturbances on the preparations of two different companies. We are now investigating a possible case of photosensitivity due to griseofulvin. So far there have been no reports of cross sensitivity in patients allergic to penicillin; even those with prior anaphylactic reactions to penicillin have taken griseofulvin without reactions. However, future use may well show all the reactions we have seen from penicillin.

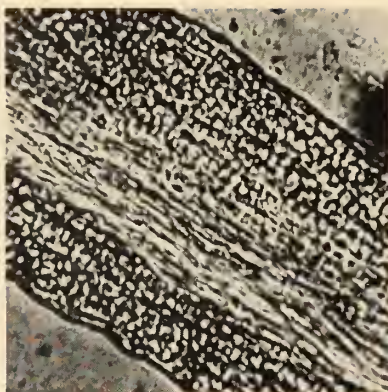
Probably the greatest harm done so far by this drug has been to the patient's pocketbook when the patient has been given the drug to cure tinea versicolor or moniliasis, or some

*The drug for this study was supplied largely through the courtesy of Dr. Kenneth Hawkins of Schering Corporation with an initial small supply also from Dr. Gavin Hildrich-Smith of McNeill Laboratories.

Note: Received for publication April 12, 1960.



Microscopic picture (high power) of skin scrapings showing hyphae (vegetable growth) of fungus. Simple but important examination to prove diagnosis and follow cases adequately.



Photomicrograph of infected hair showing the spores of the fungus. Again a simple but most important aid in proper diagnosis and follow up of cases of tinea capitis.

entity not a fungus infection. When in doubt, appropriate skin scrapings for direct microscopic examination and culture are essential for correct management. Here it should be noted that scrapings when correctly obtained and studied by an expert, will yield more positive results than culture.

In general, adults require one gram a day, children weighing 25-35 pounds, 250 mg., 35-60 pounds, 500 mg., and 60-100 pounds, 750 mg. daily. Clinical experience indicates a single daily dose may be effective, although generally divided doses are felt to provide better absorption of the drug. The major portion of the drug is excreted in the urine, but studies have shown that the drug deposits itself in all keratin forming parts and moves

outward in the normal growth of hair, skin and nails. For this reason, skin, hair and nail infections respond to treatment at different rates. The average uncomplicated case of tinea corporis needs about two weeks therapy, tinea capitis 6-8 weeks therapy and fingernail infection 3-6 months and toenails six months or longer, as toenails take longer to grow than fingernails.

These schedules are only gross approximations and certain words of caution and instructions are necessary in order to prevent relapses and infections. It should be emphasized that the drug is fungistatic, not fungicidal. Chronic cases of tinea corporis especially those of the hands and feet and those due to *Trichophyton rubrum* may take 6-8 weeks of



Before Treatment. Tinea corporis on a 60 year old white female.



After 1 week griseofulvin. Follow up. No relapse.



Trichophyton rubrum infection of 8 years duration, not responsive to any topical treatment before treatment.

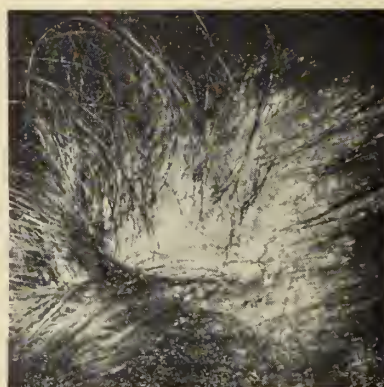


Eight months after beginning and continuing treatment with griseofulvin.

therapy and in susceptible individuals these cases of tinea corporis are sure to return if there is a concomitant nail infection that is not treated until cured, as the nail will re-infect the skin. In tinea capitis the infected areas should be shaved or manually epilated in three weeks as by that time the drug is in the keratin of the hair up to the surface of the skin. Above this level the fungus survives in the old keratin of the distal hair part, and only awaits cessation of treatment to re-infect the skin, which loses its protective supply of griseofulvin before the hair. This skin infection will re-infect the new hairs that later grow out. Certainly re-infections are and will be numerous both because of the ability of the fungus to survive under almost any condition and the unique susceptibility of some individuals to these infections. It should here be re-emphasized that more and more we are associating tinea rubrum infections with severe systemic conditions such as Cushing's syndrome, and I have even seen this in iatrogenic Cushing's syndrome, in a patient on long term anti-inflammatory steroid therapy for arthritis. Perhaps tinea capitis offers more trouble in deciding how long to carry out treatment and here the clinician's ability to find the fungus on microscopic examination is essential to good management, along with the identification of the fungus by culture as apparently some fungi respond more readily than others. Generally speaking, therapy should be continued until two negative microscopic examinations of the hair have been obtained.

Results have in many cases been dramatic. This is particularly true in long standing cases of the resistant tinea rubrum infections. Itching generally disappears by the third day in skin lesions. Kerions (the boggy inflammatory scalp lesions) begin to respond in a few days and where discomfort has been a problem, patients are usually comfortable in less than a week. One of my first patients, a lady with a generalized infection from head to toe for fourteen years, now has finger and toenails for the first time in eight years. This patient still requires therapy and perhaps there will be many more like her who will require some maintenance dose to keep them free of infection.

Since less than a year has gone by since the



Fungus infection of scalp in a 17 year old white female treated for 12 years previously as "severe dandruff." Culture showed trichophyton tonsurans infection. Four months treatment with griseofulvin needed. No relapse after six months follow up.

medication has been generally available, much is yet to be learned regarding its use. Also the question of the individual's susceptibility, questions as to why the parasite may infect one hand and nowhere else for years, these and other problems still remain a mystery. However, without question, a new milestone in therapeutics has been reached, as never before have we had a systemic medication that would have any effect on the common dermatophytes. Certainly other similar drugs will soon be available and should serve not only to provide more relief for the patient but new understanding of the metabolism of the skin, the formation of keratin and some of the

secrets of the skin, its metabolism and function in both normal and abnormal states.

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THE NEED FOR ACTIVE PROPHYLAXIS AGAINST TETANUS IN THE ADULT POPULATION

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It is important to consider the prevention of this disease in spite of the fact that there are only about 500 cases of tetanus reported in the United States each year. The number of cases reported has not fallen below this mark for some time and there may well be a great many more cases which were not reported. Of these 500 cases the mortality is still 50% and it is so simple to prevent this disease that it is important for us to consider its prevention and to understand it a little bit better.

In the last four years there have been 15 cases in the Columbia Hospital, Columbia, South Carolina. Of this number 7 died, making a mortality rate of 47%. However, the last 3 cases which occurred, all in adults, were fatal. In the South, which contains only 24% of the population, there are 63% of the deaths from tetanus for the whole country each year.

The value of active prophylaxis with the use of tetanus toxoid was graphically proven in World War II. At this time there was one case of tetanus in approximately three million armed force personnel who were injured. At the same time in the adult civilian population in this country there were 1500 deaths. I don't

The author points out that in spite of rather general use of tetanus prophylaxis there are several hundred cases of the disease in this country every year. He indicates the necessity for the administration of tetanus toxoid to the whole population.

believe that there is anything more graphic to show the value of prophylaxis than these figures. This prophylaxis was obtained by two injections of alum-precipitated toxoid, 1 ml., one month apart, or it may be obtained by three injections of plain fluid toxoid, 1 ml., one month apart. Therefore, tetanus can be prevented if people will only be given the tetanus toxoid. It is true that in adults the reactions to the toxoid are somewhat more severe. Many times I have found it better to give a smaller dose and give an extra dose or two. The alum-precipitated toxoid gives a better immunological response. However, the fluid toxoid gives less reaction. The main reaction which one gets from alum-precipitated toxoid is a sore arm and a tendency to form sterile abscesses.

Since about 1940 almost every child has had

tetanus toxoid so that a large number of young people have been immunized. All of the personnel who were in the armed forces have been immunized against tetanus. However, there still remains a large group of adults, composed primarily of women and those men who were not in the armed forces who have not been immunized with tetanus toxoid.

Now if these people receive serious injuries or any injury it necessitates the passive immunization against tetanus with the use of tetanus antitoxin, which is made from horse serum. Twenty-five percent of these recipients will get severe reactions if they have had horse serum before and 10% will get reactions if they have never had horse serum. Some of these people are so sensitive that they have died of anaphylactic shock immediately without one being able to prevent it even though they had been tested for sensitivity beforehand.

Just recently there was a death reported in the *Journal of the American Medical Association* of a young physician, 29 years old, who had a minor cut on his lower lip for which he was given tetanus antitoxin, although he had been in the armed services and he really only needed an injection of toxoid. He died from anaphylactic shock. It is very important to ask the patient if he has been in the armed forces as well as to ask him if he knows of a sensitivity to horse serum or if he is allergic to any other material. Because if he or she had been in the armed services he only needs tetanus toxoid and not tetanus antitoxin. Just last week a patient of mine was seen in the emergency room of one of the hospitals here in this city and he had been a member of the armed forces. He had a puncture wound which required tetanus prophylaxis, but instead of getting a booster injection of tetanus toxoid, he was given tetanus antitoxin and even though he was tested he got a rather mild serum sickness. This man should have only had a booster injection of tetanus toxoid.

Tetanus is a very insidious disease. The tetanus organism and its spores are found in the intestinal tract of men and animals and is present everywhere and particularly it is found where people live close together in the lower strata of society, which are more apt to be

exposed. It is insidious in its onset and one never knows when one gets it because one has many scratches and cuts for which one does not get a tetanus infection. Therefore, one many times does not have tetanus prophylaxis. It is important, therefore, that everyone be given tetanus toxoid.

If a patient has not been actively immunized with tetanus toxoid and receives an injury which requires the giving of tetanus antitoxin for passive immunization, one should then give a tetanus toxoid injection at the same time and follow-up the series. The antibody formation from the passive immunization is not disturbed. However, the antibody formation for the active immunization of the toxoid is partially delayed, but by injection of the second dose of the toxoid, the anamnestic reaction is just as great as if it had been done in the usual manner. So there really is no interference with antibody formation from the tetanus toxoid except at the immediate time when you give tetanus antitoxin along with tetanus toxoid.

The anamnestic reaction in tetanus toxoid is very great. If an individual has had tetanus toxoid within 10 or even 15 years prior to an injury, a booster injection of tetanus toxoid will give a very high anamnestic reaction and sufficient level of antibodies to prevent tetanus.

Tetanus is a severe and serious illness when it occurs, because once the tetanus toxin has attached itself to the nerve cells, there is no cure. Many times patients may be saved after they have developed tetanus but these have all not had very much tetanus toxin attached to the nerve cells.

The development of tetanus toxoid for active prophylaxis against tetanus has been one of the greatest values to mankind and unfortunately many people have not yet taken the opportunity to have such immunization. I would highly emphasize that all physicians see that their adult patients are immunized and the immunization kept reasonably up to date.

Summary and Conclusion

1. Tetanus is still an important and highly fatal disease.

2. Tetanus is preventable.
3. Everyone should be given tetanus toxoid.
4. A history of a patient having been in the

armed services since 1940 is all that is necessary to know that that individual has had tetanus toxoid.

SMALL INTESTINE TUMORS

A CASE REPORT AND SURVEY OF THE RECENT LITERATURE

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It is axiomatic in medicine that the major prerequisite to adequate treatment of any disease is accurate diagnosis. Bleeding from the gastro-intestinal tract is a common condition and may vary from slight intermittent bleeding causing a variable degree of anemia to a massive exsanguinating catastrophe requiring immediate and frequently heroic measures if the patient's life is to be saved. As with most diseases, the severity of the average case of intestinal bleeding lies between these extremes and gives the physician some time in which to attempt to pinpoint accurately the site of bleeding and, thus, more intelligently and adequately treat his patient. It is perhaps sobering to realize that in spite of our best diagnostic efforts some 10 per cent of cases of gastro-intestinal bleeding, as reported in a recent review of 5,192 such cases,¹ remain undiagnosed as to the site of the bleeding.

Small intestine tumors may, and frequently do, bleed. Due to their location they are difficult to detect by diagnostic measures short of operation. When located in the upper small bowel they may mimic other more common conditions, peptic ulcer in particular. Finally, because of the benign growth characteristics of many small intestinal tumors, prolonged symptomatology is commonly produced.

Recent contact with a case embodying many of these features, combined with the realization that one out of ten patients with significant intestinal hemorrhage remain undiagnosed led to this report. A survey of the recent literature pertinent to this type of case was also carried out.

Case Report

W. B. was a 53 year old white male machine-

worker and farmer who was referred to me and admitted to the Columbia Hospital May 10, 1959 because of gastro-intestinal bleeding.

The patient gave a history of indigestion dating back some 10 to 15 years. Symptoms initially were very vague but beginning in 1950 a definite pattern of discomfort became apparent. Likewise, symptoms became more severe and frequent. These symptoms consisted of a feeling of burning discomfort and boring type pain located in a small area in the epigastrium with, at times, some spread of the pain through to the back. The pain was stated to have never been present before breakfast, occasionally would awaken him at night and occurred most commonly an hour to two after meals. He had noted no specific article of diet as being troublesome until 3 or 4 weeks before admission when he had voluntarily stopped drinking coffee and noted some reduction in the severity of his symptoms. Prior to that time he had been drinking some 4 or 5 cups a day. The patient stated that over the years the indigestion would wax and wane in severity but he had not correlated these variations with seasons of the year nor had he ever been told he was anemic. He had had no x-ray examinations of his intestinal tract prior to the present illness. On May 4, 1959 he had used parathion to spray his peach trees. He had used this poison on previous occasions with no difficulty. Some six hours after using the poison, that afternoon, he had a normal bowel movement. This was somewhat unusual for him as he had been subject to mild constipation for as long as he could remember. An hour or two later he had another movement and questionably noted small amounts of reddish-black material in the stool. He then had two more stools in the next few hours which were definitely reddish-black in color. He reported to work as usual, however, on the 4 to 12 shift. About 8 P. M. that night he had another stool which was likewise bloody and somewhat loose in consistency. He noted some weakness following this but finished out his shift, went home, slept well and was not awakened by any discomfort. The next morning before breakfast he had another bloody, tarry stool, saw his local physician and was admitted to his local hospital on May 5. He was started on an ulcer diet, antacids and anti-spasmodics. The next day he had another tarry stool and 500 ml. of whole blood

was started intravenously. While receiving this he "fainted". He was seen shortly thereafter by his physician who found his pulse to be 40/min. Consciousness was returning, the blood transfusion was continued, the foot of the bed was elevated and the patient rallied without further treatment. He had no more stools and no more blood was given until May 9. At that time when the patient had gotten up to go to the bathroom, he had a grossly bloody stool, became weak, dizzy and fainted. His blood pressure was again found to be at shock levels, pulse 40/min and he was sweating profusely. He was given 1 ml. of Wyamine (mephentermine sulfate) intramuscularly with a prompt rise in his blood pressure and he was then given a transfusion of 500 ml. of whole blood. The following morning he was referred to me for further treatment.

An upper gastro-intestinal x-ray series had been done on May 6 and was reported as normal. While the patient had not yet vomited, he stated that in the past when the indigestion became particularly severe he would at times vomit with relief of the discomfort. Vomiting was always spontaneous.

Tonsillectomy and adenoidectomy had been done in 1929; he bled moderately following this but received no transfusion. Appendectomy had been done in 1937 without difficulty. The review of systems revealed only a history of frequent tension-type headaches for which he took aspirin or some similar preparation.

The patient's general health had shown no recent change. His appetite had remained good and he had noted no loss of weight.

Personal and family history revealed that one son had Hodgkins' Discase. The patient's father was stated to be "a hypochondriac and always sick", though still living in his seventies.

Physical examination revealed an alert, tense white male of stated age whose skin and mucous membranes were slightly paler than normal. There was no abnormal sweating; the patient showed no evidence of recent weight loss. There were no telangiectases seen. Blood pressure was 110/60, mm. Hg., P 64, T 98°. A complete physical examination revealed reddish black feces in the rectum but no other abnormalities.

Hemoglobin on admission was 11.8 grams.; erythrocytes 4.1 mil/cu. mm.; WBC and differential were normal. Blood urea nitrogen was 42 mg/100 ml. Blood sugar was normal, as was urinalysis.

The patient was put on milk and cream feedings every hour, an antacid preparation between feedings, an antispasmodic every six hours and sedation as required.

The night after admission he became weak, his BP fell to 80/50. The foot of the bed was elevated and the pressure rose to its previous levels. Hemoglobin was 10.9 grams. The patient had had no bowel movement since May 9. Following receipt of the blood report the patient was given one pint of blood. The following morning he had another episode of mild

shock and was given another pint of blood. Later that day he had a bloody tarry stool which was the seventh he had had since onset of the bleeding. During this day his blood pressure varied between 110/70 to 90/50. Hemoglobin taken that morning was 11.1 Gm. He vomited greenish fluid once that day and felt quite weak throughout the day.

In view of the evidence of continued bleeding in a man his age surgical consultation with Dr. W. C. Cantey of this city was obtained and a decision to operate was made. Preoperative diagnosis was probable duodenal ulcer in spite of the negative x-ray examination and the absence of hematemesis.

At surgery a tumor was found arising from the small intestine on the anti-mesentery border about 14 cm. distal to the ligament of Treitz. Arterial supply to this tumor was anomolous, as shown in figure 1; the venous drainage appeared to be by the usual route. On opening the lumen of the bowel a superficial ulceration was seen on the mucosal surface of the tumor. The tumor was found to be almost completely extraluminal in location. At the base of the ulcer a small blood vessel was seen from which slight bleeding was occurring. The remainder of the abdominal cavity was thoroughly explored and no abnormalities were detected. The duodenum and stomach were not opened but were normal to palpation. The tumor was removed by means of an elliptical excision which avoided the necessity of transecting the bowel.

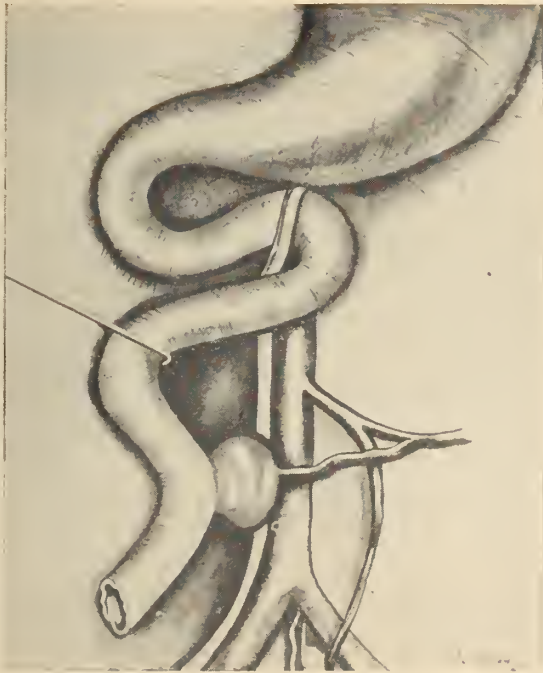
The patient made an uneventful recovery and was discharged eight days after surgery. BUN three days after surgery was 13.7 mg/100 ml. The day of discharge his hemoglobin was 12.8 Gm. His local physician reports that he has continued well, his hemoglobin remains normal and he continues to be slightly constipated.

Pathological report on the tumor described a typical leiomyoma with fairly large vascular spaces and some evidence of necrosis centrally. A small ulcer was described overlying the mucosal side of the tumor. Beneath the ulcer lay one of the large vascular spaces as well as a small artery. There was no evidence of malignancy.

It is interesting to speculate on what part the contact with parathione may have played in this man's symptomatology. There was certainly nothing to suggest the usual acute toxicity which occurs but the well-known powerful cholinergic action of this poison may have played some part in producing the acute episode.

Discussion

Whether or not this represents a rare type of lesion is difficult to determine from the literature. Reports similar to the present one, (presenting one case) are not infrequent,^{2, 5, 7, 16, 18, 19, 21} as are reports recording experience with only a few cases^{3, 4, 6, 17}. However, Oberhelman *et al*²⁰ reported four cases of leio-



Photograph of tumor showing ulceration on mucosal surface, extra luminal location and large artery.

myoma seen by them and carried out an extensive review of the literature through 1952 finding a total, including their cases, of 1105 cases of leiomyoma of the gastro-intestinal tract. Of these, some 80% were considered as symptomatic and the remaining 20% discovered incidentally at operation for some other condition, or at autopsy in cases where the tumors had apparently produced no symptoms during life. In this series of 1105 cases, 66 were found in the esophagus, 705 in the stomach, 225 in the small bowel and 109 in the colon. These authors concluded that leiomyomas of the *small intestine* were rare but constituted the single most common form of benign tumor of the entire gastro-intestinal tract. In 1956 River *et al*²¹ reported on benign tumors of the small bowel only. These authors excluded tumors arising from Meckel's diverticula, enterogenous cysts, aberrant pancreatic or other aberrant tissue origin, carcinoids, endometrial inclusions, plasmacytomas, hamartomas, granulomas, hematomas and inflammatory polyps. They reported on a total of 1,379 such benign tumors of which 179 were leiomyomas. These authors stated that asymptomatic cases, that is, those discovered incidentally at operation or autopsy, outnumbered

those cases producing symptoms by a ratio of 15 to one. Thus, it would appear that benign small bowel tumors in general and leiomyomata in particular, while sufficiently uncommon to stimulate case reports when encountered, are probably not as uncommon as individual experience would lead one to believe.

Symptoms resulting from the presence of a tumor of the small intestine may be divided into non-specific ones seen with tumors in any location, such as a palpable mass, sense of pressure, metastases, if the tumor is malignant, etc. and specific symptoms relating to disturbed function of the small intestine. The general pattern such more specific symptoms will take seems more related to the relation of the tumor to the lumen of the gut than to any other factor. Thus, *extra-luminal* tumors are prone to produce vague symptoms which may and frequently are mistaken for other diseases such as peptic ulcer, gall-bladder disease, and the like. *Intra-luminal* tumors are much more apt to be productive of symptoms relating to varying degrees of obstruction of the intestines and are commonly productive of intussusception. In the series by River *et al* previously alluded to, these authors stated that one reason for the hitherto held idea that small bowel tumors were rare was the fact that so many of the cases uncovered by them had been reported under the heading of intussusception and thus had remained unrecorded under their proper heading.

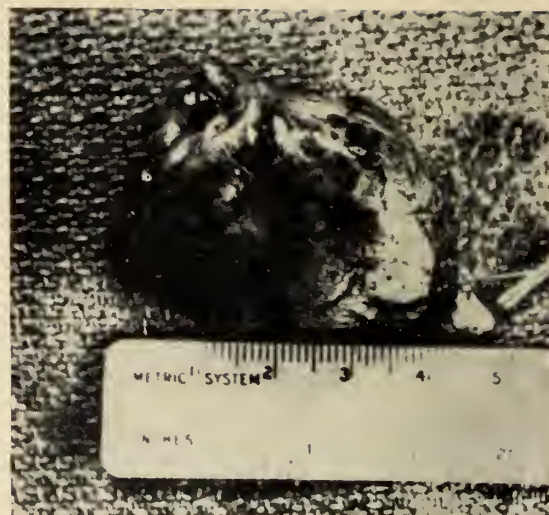
The *intra-luminal* tumors would thus appear to be of a less troublesome type, as their presence, while perhaps totally unsuspected, generally leads to a train of symptoms that results in surgery and resultant correct identification. That this happy state of affairs is not true of the *extra-luminal* tumors is well-borne out by the case presented above and many instances reported in the literature. Due to their location these tumors are often undiagnosed or misdiagnosed as other diseases. By far the most common symptom produced by such tumors is bleeding. When, as in the present case, prolonged previous symptomatology points to the more common diagnosis of peptic ulcer it is easy to see how inadequate treatment might result. Thus, Case¹³ records a case with a

history of intestinal bleeding episodes covering a five year period before correct diagnosis at operation with removal of the tumor. In another case reported by Silber³ the patient had had ulcer-like symptoms for 16 years, was admitted after bleeding from the intestines for three days, and x-ray examination showed what appeared to be a duodenal ulcer. Treatment was medical, with cessation of hemorrhage but the patient returned one month later, again bleeding, and at operation was found to have an extra-luminal leiomyoma of the upper jejunum and no apparent duodenal ulcer.

From the cases reviewed it would appear that the vast majority of patients with extra-luminal tumors of the upper intestine had symptoms indistinguishable from peptic ulceration. That this difficulty in arriving at the correct diagnosis is of more than academic interest is attested to by the recorded²¹ mortality of 14.1% in a series of 156 cases of bleeding from tumors of the small intestine.

In the reported cases reviewed it was impossible to arrive at any conclusion regarding the diagnostic accuracy of x-ray studies. They were of no value in the present case, though this condition was not specifically looked for but it is difficult to see how x-ray study could have shown either this particular lesion or the majority of extra-luminal tumors. It has been reported that tenderness over the tumor is of aid in diagnosis²⁰ but this finding was not present in the above case nor has this finding been recorded as helpful by other authors.

In the cases reviewed only one other case is recorded as showing anomalous blood supply to the tumor. This was a case of leiomyoma of the terminal ileum reported by Borrie¹⁵ in which bleeding led to surgical exploration. At operation the tumor was found to receive its arterial supply from the gastro-epiploic arch. This tumor was only slightly larger than the present one reported. The size of the artery in the present case was most striking as shown in the illustration. Such blood supply must have been present since early in fetal life. Was the tumor there all the time but not growing or might the abnormal blood supply have brought about changes in local conditions conducive to the growth of the tumor in later life? As



Artist conception of blood supply arising from branch of inferior mesenteric artery supplying the tumor.

mentioned earlier, the vessel did not appear to contribute blood to any other region of the gut and the usual branches of the superior mesenteric artery were normal in this location as well as elsewhere in the mesentery. The excessive vascularity of these tumors is alluded to generally in the literature but was commented upon specifically in two other cases. Philip¹² reported a case of leiomyoma of the jejunum presenting rather dramatic bleeding. At operation the tumor was found to contain many markedly dilated blood vessels thought to be veins and the site of bleeding was from the rupture of one of these vessels into the lumen of the gut. In another case report by Wolfe and Tesler⁸ a leiomyoma of the lower ileum had undergone extensive cystic changes from necrosis and hemorrhage and simulated a giant ovarian cyst.

It would appear then, that as with any other uncommon disease producing no specific diagnostic signs or symptoms, a high index of suspicion remains the most helpful aid to adequate treatment. While the author, being medically biased, believes that most peptic ulcer patients belong under medical supervision with their stomachs whole and emptying through the pylorus, when gastro-intestinal bleeding presents himself it would behoove us all to recall the one out of ten such cases that at present remains an enigma. When really adequate abnormalities are not shown by

x-ray, indicative of a peptic ulcer, or some other likely cause of bleeding is not found; the one in ten figure might be decreased if the possibility of the presence of a small intestinal tumor is brought to mind. Unfortunately, it would appear that recourse to our surgical colleagues is, at present, the only certain method of resolving the question.

In summary, the case presented exemplifies many of the aspects of medical experience with extra-luminal small bowel tumors generally. That this is not as rare a problem as might be thought is shown by the extensive series of

similar cases in the literature. And, finally, as bleeding is the most common symptom of such tumors, and as these tumors are almost impossible to discover short of operation, a higher index of suspicion relative to the possible presence of such tumors might reduce the large number of patients with gastro-intestinal bleeding now receiving inadequate treatment due to insufficient diagnosis, as well as reducing the 14.1% mortality recorded in the literature at present as occurring in patients bleeding from tumors of the small intestine.

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EMERGENCY REPAIR OF OCCLUDED ILIAC ARTERY

A SUBSTITUTE METHOD

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Accidental acute occlusion of an iliac artery during a surgical procedure within the abdomen presents a serious medical emergency. If the collateral circulation is not adequate, there is a good possibility of gangrene developing in the extremity distal to the area of occlusion. There is the considerable possibility that trauma to the vessel at time of occlusion will cause a propagating thrombus to develop which may then initiate the development of gangrene of the involved extremity in spite of initial adequate collateral circulation.

The ideal repair of an occluded iliac artery will be direct approach with release of the occlusion and repair of the vessel or insertion of a replacement or by-pass graft as indicated. Occasionally it may happen that a patient is in such poor condition that the surgeon may doubt the advisability of embarking on a major abdominal procedure which will require extensive abdominal exposure and dissection of aorta and iliac arteries. The case to be reported illustrated these problems and their solution.

Report of A Case. A 49 year old white woman was admitted to the S. C. Baptist Hospital on May 9, 1960 with a chief complaint of recurring right renal infection. In 1942 a right nephrolithotomy had been performed. In 1943 a right perirenal abscess was incised and drained. In 1945 a nephrectomy was attempted but because of inflammatory reaction around the kidney was discontinued. In the ensuing years the patient had recurring urinary tract infections and recurring purulent drainage from a sinus in the right flank. In June 1959 a local excision of the draining sinus in the right flank was performed, but this shortly broke down and began to drain purulent material again. Intravenous pyelograms revealed an essentially normal kidney on the left but greatly diminished function on the right. On May 13, 1960 a right nephrectomy was performed. There were extensive scarring and adhesions around the area of the right kidney and it was not possible to identify adequately the structures in that area. A five hour operative procedure was required to perform the

This is a detailed report of a case in which an arterial bypass from the common femoral artery of the normal leg was constructed to the common femoral artery of the other leg in which there was iliac occlusion.

nephrectomy and there was considerable bleeding requiring transfusion of six units of blood. During the operation there was some brisk bleeding from the depths of the incision which was controlled with suture ligatures. The patient was in mild shock near the end of the procedure.

One-half hour after the end of the operation it was noted that the patient's right leg was pale, cold, and pulseless. Examination revealed palpable but weak femoral, popliteal, posterior tibial, and dorsalis pedis pulses in the left leg. The femoral pulse was not palpable on the right and no pulses distal to this were palpable. The right lower extremity was cool and pale and the patient complained of a numb sensation in this leg. Her blood pressure was 85/60 mm. Hg. and the pulse rate 110. Oscillometrics showed an excursion of four in the left calf and zero in the right calf and right thigh. Two and one-half hours after the end of the operation the patient was taken back to the operating room where the right femoral artery was explored under local anesthesia. When the artery had been exposed, it was found to be pulseless. A linear arteriotomy incision was made and there was found to be moderate back bleeding but no bleeding from the proximal side. Catheters and probes were advanced 10 cm. proximally and met a firm obstruction. Repeated attempts were made to aspirate a thrombus in this area, but they were of no avail. A second incision was then made in the left femoral triangle and the left femoral artery was dissected out. A 10 mm. knitted dacron De Bakey arterial graft was preclotted and sutured into the side of the common femoral artery on the left. This graft was then tunneled across the lower abdomen in the subcutaneous tissue just anterior to the rectus fascia with the use of local anesthesia. An end-to-side anastomosis was performed to the right femoral artery. A small ellipse of the vessel wall was removed from each of the femoral arteries prior to doing the anastomosis. When the occluding clamps were released, pulsatile blood flow was established through the graft and there was good pulsation of the right femoral vessels. The

wounds were closed in layers with interrupted silk and the patient sent to the recovery room in good condition.

The patient had an uncomplicated postoperative course. She had no pain in the right leg. Immediately following operation the right leg became warm and of equal temperature with the left. There were good femoral, popliteal, posterior tibial, and dorsalis pedis pulses on the right. It was not possible to detect a difference in the pulses of the two legs. The patient was ambulated on the fourth postoperative day and was able to walk without difficulty. Both femoral incisions healed per primum and the nephrectomy incision healed except for a small opening where drains had been inserted. This subsequently healed completely. The patient was discharged on the twelfth postoperative day at which time she was completely ambulatory.

Following operation the patient has done well and has returned to full activities with no limitation. She is able to walk any distance desired and to climb stairs without leg fatigue. Five and one-half months following operation examination revealed equal pulses in both lower extremities in all areas. A pulsating graft could be palpated in the subcutaneous tissue of the suprapubic area. There is a grade II systolic bruit audible over the left femoral region and a grade I systolic bruit over the right femoral area. Oscillometric examination shows an excursion of 2.5 right thigh and 3.0 left thigh and 6.0 right calf and 7.0 left calf.

Discussion

It was apparent that this patient had suffered complete occlusion of the right iliac artery, and probably the common iliac, during the nephrectomy operation and from the examination of the right lower extremity it was thought that gangrene would be inevitable. This patient had just undergone a lengthy and shocking operative procedure and there had been gross infection in and around the right kidney. It was considered that another major abdominal procedure at this time in which it would probably be necessary to place a graft in an infected field would be quite hazardous. Since the diameter of the common femoral artery is fairly large, it was thought that an increased run off area beyond the common femoral artery would allow an increased flow

of blood through this artery. The operative procedure performed was a relatively minor one performed under local anesthesia without a further drop in blood pressure. The postoperative follow-up has been most gratifying in that the patient feels that she is completely normal. A long term follow-up may show some decrease in flow through this graft and there is the possibility that occlusion could develop in the graft. If such a situation should occur, a primary by-pass procedure could be done between the aorta and the iliac vessels at a time when the patient was in much better condition.

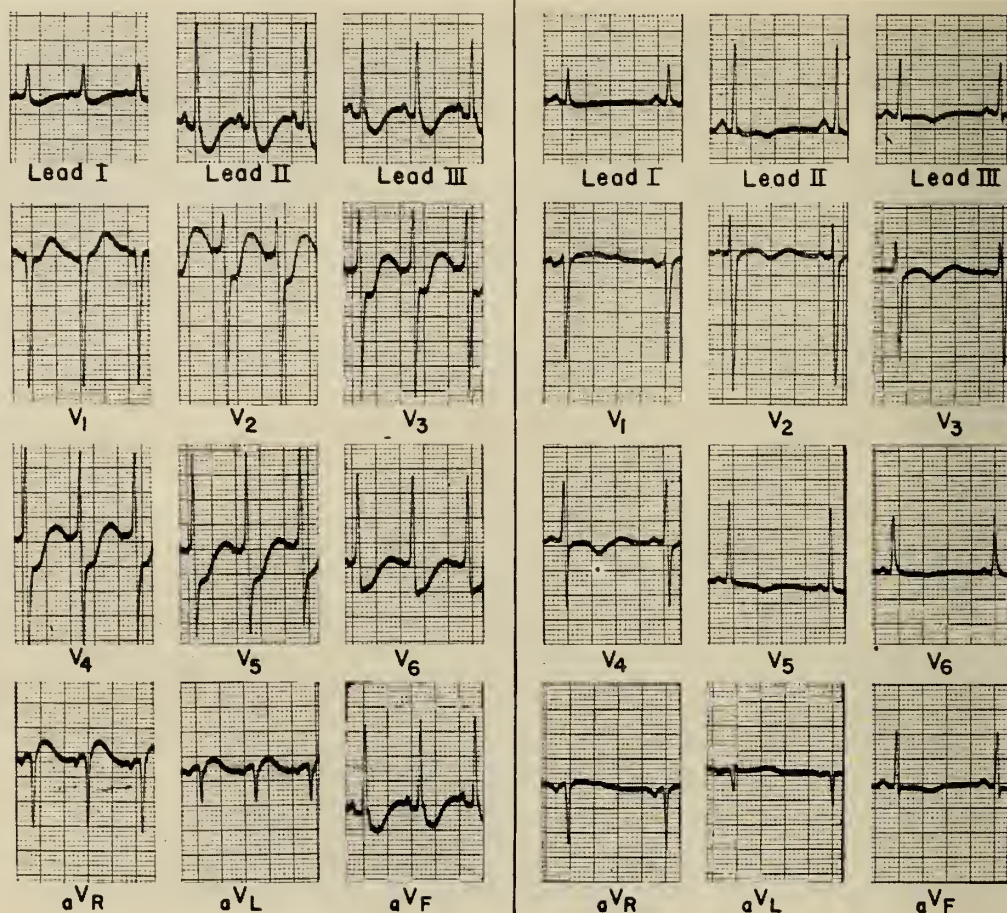
The principle of bringing the blood supply of an entire lower extremity from the vessel going to the other extremity has not been stressed to my knowledge. Admittedly this is an inferior procedure to a primary by-pass or repair of the point of occlusions. This principle should receive consideration in those patients with unilateral iliac occlusion in whom a major abdominal procedure is thought to be contraindicated. Particular application might be found in those people with arteriosclerotic occlusion of one iliac artery in whom the other had remained patent. Since many of these patients have had one or more coronary occlusions, this procedure would offer a much safer method of palliation.

Summary and Conclusion

The successful application of an arterial by-pass from the common femoral artery of a normal leg to the common femoral artery of a leg in which the iliac artery is occluded is presented. The postoperative period has shown the patient to be free of symptoms of vascular insufficiency in either leg. This principle is suggested in those patients with vascular occlusion of one iliac artery in whom the operative risk of a primary repair of the occluded segment would be excessive.

MEDICAL COLLEGE CLINICS

THE MEDICAL COLLEGE OF SOUTH CAROLINA



ELECTROCARDIOGRAM OF THE MONTH

Diabetic ketosis

DALE GROOM, M. D.

Case Record—The electrocardiogram on the left was made at the time of admission to the hospital of a 52-year-old colored woman with uncontrolled diabetes and what subsequently proved to be carcinoma of the pancreas. Her history of weakness and marked loss of weight during the preceding several weeks suggested that her diabetes was of recent onset and of rapidly progressive severity. At the time this tracing was recorded she was semi-comatose, dehydrated, with a blood sugar of 532 mg./100 ml. and ketonuria. Concurrently, electrolyte studies disclosed hypo-

kalemia and an elevated CO_2 combining power indicative of some degree of metabolic alkalosis, perhaps caused by a week of persistent vomiting.

When the electrocardiogram on the right was taken two days later her serum potassium had risen from 2.97 to 3.95 mEq. as a result of intensive treatment with insulin, potassium and intravenous fluids.

Within a month the patient succumbed to the carcinoma. Gross and microscopic examinations of the heart revealed remarkably little atherosclerosis of the coronary arteries and no evidence of any old or recent myocardial infarction.

Electrocardiograms—Before treatment there is a sinus tachycardia at a rate of 130. Of major interest is the very marked depression of S-T segments in most precordial leads—5 to 6 mm.—with perhaps some reciprocal elevation though of much less magnitude

in aVR. The T waves appear to be pulled down by the S-T depression but are generally upright in these leads.

Following treatment the rate has declined to about 68, still a regular sinus rhythm, with a minimal increase in the P-R interval to 0.14 commensurate with the slower rate. There is no significant S-T displacement in this tracing. Throughout, the T waves are flattened or inverted and are followed by prominent U waves (seen especially well in V_2 , V_3 and V_4) which, if present previously, were obscured by the other complexes. Both tracings were correctly standardized so the slightly decreased amplitude of QRS complexes in most leads probably represents an actual decrease in depolarization potential.

In neither tracing is there any evidence of myocardial infarction in the QRS complexes.

Discussion—Uncontrolled diabetes which progresses to a stage of ketosis, acidosis or coma is associated with a complex array of electrolyte disorders capable of altering profoundly the electrocardiogram. Probably the most consistent and well recognized alterations are those due to the hypokalemia. The electrical effects of disturbances in phosphate, magnesium and other ions, and of the inordinately high blood sugar level itself, are as yet not unraveled.

The cardinal sign of hypokalemia is accentuation of U waves. For many years the combination of a heightened U wave following immediately upon the often decreased or flattened T wave was misconstrued as a prolonged Q-T interval, but in leads where the T wave is well demarcated (e.g., II and III in the tracing following treatment) that interval can be seen to be normal. Additionally, ectopic beats, flattened or inverted T waves, and high peaked P waves are common accompaniments of hypokalemia. Severe depletion of potassium is said to produce depression of S-T segments, an extreme example of which is shown here.

It should be emphasized that these alterations in the electrocardiogram depict the level of *intracellular* potassium, and that the serum level may or may not disclose a deficiency. Hyperglycemia, like digitalis, tends to drive potassium out of the muscle cell, while insulin has the reverse effect. Actually it is possible to get an elevation of serum potassium resulting from a decrease in the intracellular level, but when that ion is low in the serum it usually denotes a deficiency in all tissues, including the myocardium. Note that while this patient's serum K had risen to the normal range (3.5 to 5 mEq.) when the second tracing was made there are still signs of hypokalemia which remained until considerably more potassium and insulin had been administered.

Depression of S-T segments of this degree is ordinarily regarded as a manifestation of ischemia. Its mechanism here is uncertain. Anoxia can cause a current of injury in a normal heart¹ and perhaps deprivation of other essential metabolites may do the same. Both myocardial and brain tissue are believed to be capable of utilizing glucose in the absence of

insulin. Yet patients with uncontrolled diabetes do go into coma—conceivably a cerebral counterpart of such electrical changes as these in the myocardium—the metabolic basis of which is still obscure.

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POSTOPERATIVE COMPLICATIONS— IV WOUND INFECTIONS

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The incidence of postoperative wound infections has been greatly reduced by improved technique, antibiotics, refined suture material, and better methods of sterilization. They still occur, however, and increase the length of hospitalization, prolong the convalescent period, and lead to other sequelae, such as, draining sinuses, herniae, and painful scars. The following case is illustrative:

Case Report: J.S., a 50 year old negro male, was admitted to the Medical College Hospital on January 15, 1960 with symptoms and signs indicating inflammatory disease in the right upper abdominal quadrant. Operation several days later revealed the presence of a sub-hepatic abscess and empyema of the gallbladder. Cholecystostomy, extraction of calculi, and drainage of the abscess were accomplished. It was decided that conditions were not favorable for cholecystectomy but that this would be done after a proper interval as an elective procedure. His postoperative course was satisfactory and he was discharged and readmitted on March 26, 1960. The cholecystostomy tube was in place. Cholecystectomy was performed on March 28, 1960. The wall of the gallbladder was thickened and chronically inflamed. There was no residuum of the previously drained sub-hepatic abscess. He remained febrile for 5 days following operation. On the 5th postoperative day, inspection of the wound revealed that it was fluctuant in the center. All of the sutures were removed and the abscessed wound was opened widely down to the anterior rectus sheath. The fever abated immediately and the patient felt much improved. Cultures of the wound abscess revealed *Staphylococcus aureus*, virulent. This same organism had been cultured from the cholecystostomy sinus tract at the time of admission.

Discussion

The wound of this patient probably became contaminated from organisms present in the cholecystostomy sinus tract. Some other vector could have been the source of the contamination, however. Regardless of the source, the wound infection added greatly to the patient's discomfort, prolonged the hospital course, increased the cost of hospitalization, and delayed return to his gainful employment.

Wound infections caused by *Staphylococcus aureus* have increased during the past decade but the incidence of those caused by enteric organisms have remained about the same. Wounds infected with

enteric organisms are usually those created for operations on the gastro-intestinal or genito-urinary tract. Some are due to breaks in technique while others arise from unavoidable contamination of devitalized or poorly nourished tissues. A certain number of these infections will continue to occur despite all preventive measures. The incidence will be proportionate to the efforts with which grossly contaminated wounds or wounds that exhibit poor healing potential are handled.

The staphylococcal infection in a clean wound is an avoidable infection and is the result of a break in aseptic technique occurring either in or out of the operating room. This organism is found very widely in nature. It is commonly found on the skin and grows in the ducts of sweat and sebaceous glands. It is frequently present in the nasal passages, mouth, and pharynx. Most of the pathogenic strains are coagulase positive. It is commonly the organism found in skin and subcutaneous abscesses and is rarely a cause of lung abscess and septicemia. Persons having close contact with hospital patients are more frequently carriers of the antibiotic resistant strains than those in the general population.

Because of this widespread distribution of the staphylococcal organisms, there are many routes whereby the organism can reach the open wound. Altemeier,¹ who has given considerable attention to this problem, believes the most significant method of transmission of staphylococcal infections within hospitals is by contact of patient and personnel either directly or indirectly. He believes that the most important components of the hospital reservoir of antibiotic resistant staphylococci are the patient, professional and non-professional personnel, and the materials or equipment coming in direct contact with them. On this basis, he recommended measures whereby more effective and realistic control of hospital acquired staphylococcal infections could be exercised. It would behoove every surgeon to read and digest these principles.

Wise and associates² obtained cultures from many different regions of the operating room and from articles used during the course of 71 operative procedures. The results indicated that there were many sources of staphylococci in the operating area. Adams and Fahlman³ carried out a similar study and reached the same conclusion. Subsequently, by instituting a program of near total sterility in their operating rooms, the incidence of infections in clean wounds was reduced to 2 in 800 cases.

Examples of breaks in technique which result in contamination of the operating suite are given in the following reports. Sompolinsky and associates⁴ reported an outbreak of staphylococcal wound infections which rose to an incidence of 37 percent. By a careful investigation, two of the operating room nurses were found to be staphylococcal carriers. Not only were they carriers, but they lowered their masks to converse during the course of an operation when they were not scrubbed. This practice was stopped

and the epidemic ceased. Blowers and associates⁵ reported a similar outbreak which required temporary closure of their unit. Their investigation revealed that contaminated blankets were brought to the operating room from the ward with the patients. On many occasions the blankets were "shaken out" in the operating room resulting in marked contamination of the air with staphylococci. This practice was stopped and the epidemic ceased. Shooter and associates⁶ discovered that their ventilating system was bringing the ward air directly into the operating room. The cultures of the air in the ward were high for staphylococci. When this fault was corrected, the incidence of wound infections dropped markedly. These and many other reports demonstrate how many factors can result in wound contamination with virulent organisms at operation. These causes vary from institution to institution and from time to time vary in any one institution. In one situation the house-keeping and laundry might be at fault, whereas in other situations the operating suite, the surgical dressing technique, or existing carrier problem might be at fault.

In a recent survey in our own operating rooms, petri dishes were placed in the operating field. Of 148 petri dishes, only 3 showed no growth of bacteria. Nine of the 145 with colony growth had significant contamination from virulent organisms. Fortunately, none of these patients developed a wound infection. In addition, 173 clean wounds were cultured just prior to closure. Of these 122 were contaminated. These studies support what others have found that most operative fields and wounds are contaminated at the end of an operation. The determining factors in wounds becoming infected, therefore, must be related to the degree and virulence of the contamination, the host resistance, and the amount of devitalized tissue and blood remaining in the wound.

Administering antibiotics prophylactically to post-operative patients should be discouraged. Indiscriminate use of these antimicrobial drugs will lead to the development of resistant strains of organisms. Reducing the incidence of infections in clean wounds can only be brought about by enforcing measures designed to control the hospital reservoir. These measures would include isolation of patients with draining wounds, rigid aseptic technique in the operating room, education of professional and non-professional hospital personnel, and prevention of hospital personnel having an active staphylococcal infection from having contact with patients.

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- rooms. Surg. Gynec. & Obst. 110:367, 1960.
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6. Shooter, R. A., Taylor, G. W., Ellis, G., Ross, J. P.: Postoperative wound infection. Surg. Gynec. & Obst. 103:257, 1956.

ACUTE GLOMERULONEPHRITIS IN THE ADULT

CHEVES MCC. SMYTHE, M. D.

Acute glomerulonephritis in a child is usually a benign disease. In rheumatic fever the younger the patient at the onset of the disease, the more probable he is to develop severe and permanent cardiac changes. The reverse relationship is true in glomerulonephritis in that the younger patient can be expected to go on to complete recovery in about 95% of cases.¹ Even partial remission from glomerulonephritis is not common in adults, and the following case is reported for this reason.²

L.L.R., MCH #17865, was first seen in the Medical College Hospital with severe angina pectoris in 1958 at age 47. At that time his blood pressure ranged between 210/100 mm. Hg. and 140/90. There was minimal arteriolar spasm in the eyegrounds. The urine concentrated to 1.016 and contained a trace of albumin. During the fall of 1958 and winter of 1959 his angina slowly improved. The blood pressure ranged between 160/100 to 130/80.

Toward the end of November of 1959 he developed a very severe sore throat. About two weeks later his ankles began to swell. He also had some vague back discomfort and malaise but was without fever. The swelling then progressed to involve his legs, lower back, face, and hands. He noted no blood in his urine, but when he consulted his physician, he was found to have hematuria and heavy albuminuria. There was no change in his urinary habits. As soon as his business allowed, he was referred to the Medical College Hospital for treatment.

On physical examination, edema was the most striking finding. He had pitting edema which involved the lower part of the legs, trunk, sacrum, arms, and face. The blood pressure was 210/120. He weighed 211 pounds. There were Grade I arteriolar changes in his fundi. There was no evidence of heart failure or liver disease.

The first urine specimen showed specific gravity 1.015. There was a 4+ reaction for protein. The sediment contained 5-6 white cells, 25-30 red cells, many coarse granular and cellular casts. No red cell casts were positively identified. Hemoglobin, red cell count, white cell count, and differential were within normal limits. A throat culture contained no beta hemolytic streptococci, and a blood antistreptolysin titer was 1:160. A urine culture was negative. Intravenous pyelograms, a chest x-ray film, and an electrocardio-

gram gave no additional information. Serology was negative.

The initial blood urea nitrogen was elevated to 59 mg./100 ml.; blood creatinine 3.0 mg.; serum calcium was normal at 9.5 mg., but serum phosphorus was slightly elevated at 5.3 mg. Total serum proteins were only 4.64 Gm., and serum albumin only 1.64 Gm. Quantitative urinary protein excretion was 3.04 Gm./day.

During his first four days in the hospital, the patient's weight fell from 211 to 207 pounds, and his blood pressure stabilized at 180/110. He was then started on hydrochlorothiazide, 50 mg. twice a day, and his weight fell rapidly to 188 pounds. The blood pressure reached a lower plateau of 160/100. His urine then became grossly bloody on his 8th hospital day, and his vague flank pains recurred. These pains were controlled by aspirin.

On the 10th hospital day, renal biopsy was done. (Fig. 1). The specimen was remarkable for very acute glomerulonephritis superimposed on chronic changes.

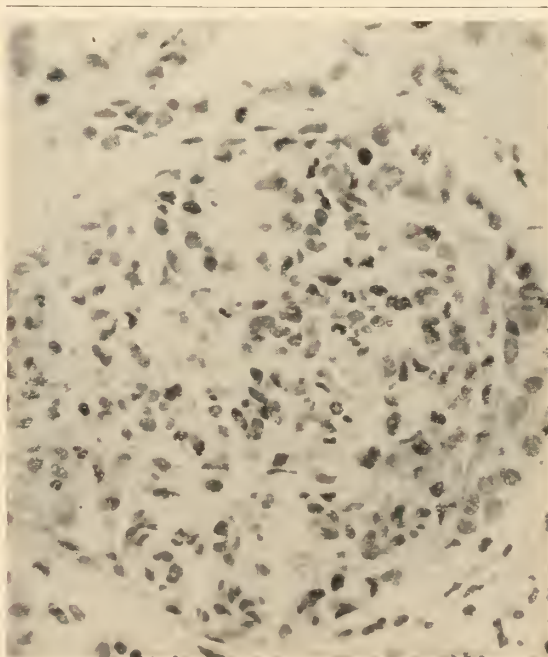


Fig. 1 x400. This glomerulus is remarkable for intense swelling obliterating all the capillary lumens. In addition, there is proliferation of the cellular elements of the glomerulus, as well as infiltration with polymorphonuclear leukocytes. Beginning crescent formation can be seen to the right of the slide. These changes are typical of a very acute glomerulonephritis.

He was then started on prednisone, 80 mg. per day, and erythromycin, 2 Gm. per day. These had no further effect on the course of his disease. His blood urea nitrogen remained elevated at 54 mg. and the urine remained grossly bloody. After 3 weeks in the hospital he was discharged home to complete bed rest on a 40 Gm. protein diet. He was advised to take 50 mg. of hydrochlorothiazide twice a day if his weight went over 188 pounds.

Having remained at bed rest at home for six weeks, he returned for a follow up visit feeling well. Blood pressure was 160/90, and physical examination was otherwise unchanged. His gross hematuria had disappeared, but voided urine was loaded with albumin, contained many red and white cells, a variety of granular casts, and many red cell casts. However, his blood urea nitrogen was normal at 16.7 mg. Creatinine clearance was 63 ml/min. (normal, 110 ml/min.). Urea clearance was 67 ml/min. (normal, 75 ml/min.), and phenolsulfonphthalein excretion was 25% in the first 15 minutes. He was advised to remain at bed rest for another six weeks.

On his next visit he was asymptomatic. Physical examination and urinary function tests were unchanged. The demands of his business had become so imperative that he was allowed to resume normal activity. When last heard from he was doing well.

Discussion

This well may not have been this man's first attack of glomerulonephritis, but rather a recrudescence of chronic disease. The modest hypertension and trace of albumin in his urine the year before the acute attack suggests this. However, two weeks after a severe pharyngitis, he developed edema, hypertension, proteinuria, and hematuria. On biopsy there was very acute glomerular inflammation present. This means he had an acute glomerular disease whether it was his first attack or not.

The first point to be stressed in this man's care is the place of bed rest. The observation is an empiric one and has been challenged often. However, most authorities feel that patients at rest do better than those who are allowed unrestricted activity. Also, renal blood flow is greater in the recumbent position, and patients with active nephritis have marked increases of their proteinuria and hematuria when they get up. This patient's willingness to remain at rest for 3 months probably played a part in his degree of recovery, even though he remains with damaged kidneys.

Intensive experimental study of the pathogenesis of

glomerulonephritis in man and animals has suggested, but has not proved that an antigen antibody-like reaction in the glomerulus underlies the inflammatory lesion. During the acute phase of an infection with a nephritogenic streptococcus, it is thought that protein is released from the glomerulus. In the quiescent phase between the infection and the nephritis, antibody to this antigen is being made. This antibody preferentially localizes in the glomerulus. When the antibody level becomes critically elevated, there is a sufficiently intense antigen antibody reaction to result in the clinical picture of acute glomerulonephritis.³

Theoretically, the antiphlogistic properties of the adrenal steroids should find ideal application in glomerulonephritis. Empirically in acute glomerulonephritis, there is no response to steroids. Why this is true is unknown. This man was given steroids because his heavy proteinuria with lowered serum albumin faintly suggested a nephrotic picture.⁴ For equally unknown reasons, nephrotic patients will show diuresis on steroids even though overall renal function may not improve.

Summary and Conclusions

1. Although acute glomerulonephritis is more common in childhood, it is seen in adults.
2. The disease carries a poorer prognosis in adults than in children.
3. Bed rest is stressed in the care of acute nephritis.
4. Although theoretically they should be helpful, empirically adrenal steroids have been found not to alter the course of acute glomerulonephritis.

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STORIES ABOUT DOCTORS

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The pre-medical student, the medical student, or the young doctor needs to learn how to become a really great physician. This includes learning many aspects of human life through experiences which cannot be taught in medical school.

Some people learn only through their own experiences; some learn through awareness of the experiences of others. Many of the stories of this list can help in learning vicariously some of the obligations and compensations of the life of a physician. They show his relationships to his patients, their families, and the community. With or without intending to do so, many of the stories show clearly the tremendous joy and satisfaction which the purposes and life work of a physician bring to the hard-working men and women who choose this career.

These books have been chosen for variety—in geographical location, socio-economic level, historical setting, and prose style. Some are summer hammock reading, some valued belles lettres, and others are good translations. Many appear in paper-back editions.

Some are appropriate for young readers, and many will interest mothers and wives of medical students and young doctors.

In most of the stories the physician plays an important role; in a few others, usually written by physicians, there are passages portraying excellent observations of various illnesses.

We shall be very glad to hear from any reader who has a suggestion for adding to the list, or who considers some book now on it unworthy of a place.

FOOTNOTES

1) Key to symbols.

° especially recommended by the consultants.

°° most highly recommended by the consultants.

y suitable for young adults (ages 14-20).

The symbols listed above were taken from the Fiction Catalog, The H. W. Wilson Company, New York.

2) Reviews from Fiction Catalog were written by consultants for that service.

3) Reviews from Book Review Digest, H. W. Wilson Company, were printed originally in the newspaper or journal named at the end of each review.

Adams, Samuel Hopkins: °CANAL TOWN, A

NOVEL.¹ London. Forum Books, 1944, \$1.00, 465 pp. Palmyra, N. Y. in the 1820's during the building of Erie Canal is setting. The story concerns the problems of a young doctor who attempts to overcome prejudice and ignorance and to clean up sanitary conditions in the town.

Ashton, Helen: DOCTOR SEROCOLD; A PAGE FROM HIS DAY-BOOK. N. Y., Doubleday, 1930, 305 pp.

The story of one day in the life of a family physician of 65 in a fine old English provincial town. This detailed record of his relations to patients whom he has known, mind and body, for forty years, is a progressive revelation of the kindliness, and crotchiness, penetration, intolerance, and deep human sympathy which make up his character. Cleveland.²

Baldwin, Faith: MEDICAL CENTER. N. Y., Farrar and Rinehart, 1940. 370 pp.

Balzac, Honoré de: COUNTRY DOCTOR. Translated by Ellen Marriage, N. Y., (Everyman's Library) Dutton, 1833, 287 pp.

In this practical philanthropist, the reformed sinner, who becomes a public benefactor, an ideal figure is created, a great soul, unselfish, full of love for man, unconquerably patient. Bakers' Best.

Barker, S.: SWEAR BY APOLLO. N. Y., Random House, 1958. 306 pp., \$3.95.

Historical novel of a young New Hampshire doctor, who, after the death of his wife, goes to an island off Scotland, and of his fight against small-pox there. Interesting picture of medical training in late 18th century; for mature readers.

Baroja y Nessi, Pio: TREE OF KNOWLEDGE, translated from the Spanish by Aubrey F. G. Bell. N. Y., Knopf, 1928. 329 pp.

Has long been regarded as one of his best works, a rounded and finished attempt to put into fictional form the peculiarly cynical and bitter philosophy which is his own. It is . . . an unsparing picture of life in Spain, of life in medical schools, in a small town and in Madrid . . . It follows the career of a physician . . . (who) eventually finds the fruit of the tree so gall bitter that rather than continue to eat it, he takes his own life. Baroja makes this act a direct protest against the state of civilization in which Hurtado is forced to live. N. Y. *Herald Tribune*.³

Certain clinical portions may revolt those with weak stomachs, and probably only specialists will enjoy twenty-four pages of philosophical dialogue which come directly in the middle of the book. *The New Republic*.

Barton, Betsy: THE LONG WALK. N. Y., Duell, 1948. 282 pp., \$3.00.

The scene of this novel is the wing of a veteran's hospital which houses the spinal injuries, the men who are permanently and helplessly crippled, who must face a future holding no miracle which will restore to them the use of their legs. The interplay of the personalities of a group of these men, the doctors who treat them, the women who

- try to give them back a reason for living, is the plot of 'the Long Walk'. *Literary Guild Review*.
- Bellamann, Henry: *KINGS ROW*. N. Y., Pocket Books. 1940. 674 pp. 50¢.
- Long novel of many characters, set in a small midwestern town, 1890-1910, as seen by Parris Mitchell, doctor and psychiatrist. For mature, thoughtful readers.
- Bottomé, Phyllis: **THE MORTAL STORM*. Boston, Little, Brown, & Co., 1938. 357 pp.
- Daughter of a famous scientist in Nazi Germany escapes alone, to use her medical education. Not a horror story but rather a story of human waste and shattered romance.
- Bottomé, Phyllis: **PRIVATE WORLDS*. N. Y., Houghton, Mifflin, & Co., 1934. 342 pp., o. p. 1950.
- The scene of the story is a hospital for the insane, and three of the principal characters are psychiatrists; one, the superintendent, and the other two a man and a woman doctor, are his co-workers. Living under the same roof, the insane with their strange fantasies and the sane with their emotional problems inwardly upsetting if outwardly controlled, are revealed as souls alike withdrawn into their 'private worlds'. *Book Review Digest*.
- The author "has here an unusual background which she handles expertly, and she has a situation with all the elements of tragedy. She takes all these elements, and because she weaves through them one of the most charming and idealistic love stories of recent days, she gives us a novel whose essential atmosphere is a happy one!" *Boston Transcript*.
- Brand, Max: *CALLING DOCTOR KILDARE*. N. Y., Dodd, 1940. 210 pp.
- Brandon, Evan: *GREEN POND*. N. Y., Vanguard, 1955. 506 pp.
- Story set in the Carolina red land, from Civil War to the present, specially about Old Doc, the traditional general practitioner and his sons, one a minister and the other a surgeon.
- Brunngraber, R.: *RADIUM, A NOVEL*. Translated from German by Eden and Cedar Paul. N. Y., Random House, 1937. 480 pp.
- Beginning with the early history of the Curies . . . discovery of radium . . . book shows effects of discovery on world, therapeutic uses to cure certain types of cancer in England and a Belgian banker shows us big business controlling the price until radium is almost unobtainable. *Manchester Guardian*.
- Buck, Pearl S.: *Y° EAST WIND: WEST WIND*. London, Forum Books, 1930. 277 pp., \$1.00.
- The conflict between the old China and the new is the theme of this absorbing, delicately written chronicle. The daughter of a noble family, trained for wifehood in the old customs and traditions and betrothed since childhood is married to a Chinese of the new era who has received his medical training in America. It is only by adopting western habits that the little bride finds love and happiness. *Cleveland*.
- Cable, George Washington: *DR. SEVIER*. N. Y., Scribner, 1884. 473 pp.
- Story is laid in pre-Civil War New Orleans; Dr. Sevier learns that to do good is finer and better than to demolish evil.
- Caldwell, Janet Taylor: *DEAR AND GLORIOUS*
- PHYSICIAN*. N. Y., Doubleday and Co., Inc., 1959. 574 pp.
- This is an imaginative reconstruction of what could have been St. Luke's early life. In *Readers Digest Condensed Books*, Spring, 1959.
- Cambridge, Elizabeth (pseud.): *HOSTAGES TO FORTUNE: A NOVEL*. N. Y., Putnam, 1933. 304 pp., \$2.50.
- Charming account of the daily life of a doctor and his wife in a small English village, who work and save in order to educate their children.
- Camus, Albert: **THE PLAGUE*. Translated from French by Stuart Gilbert. N. Y., Knopf, 1948. 278 pp., \$3.00.
- Tells how bubonic plague strikes a North African city, and of its various effects upon a group of people.
- Carfrae, E.: *FISH IN THE SEA*. N. Y., Putnam, 1937. 264 pp.
- Two English girls . . . are ambitious to become doctors. Mildred takes up practice in the hospital at Nogassi in the West Indies; Gay, defying parents who have planned a social career for their daughter, also becomes a qualified physician—and falls in love. Her struggle to choose between marriage and a professional career becomes the story's main concern. *Book Review Digest*.
- Chandler, Caroline: *SUSIE STUART*, M. D. N. Y., Dodd, Mead & Co., 1941.
- Chekhov, Anton Pavlovich (M. D.): **STORIES OF ANTON TCHEKOV*; edited with an introduction by Robert N. Linscott. N. Y. Modern Library, 1932. 448 pp., \$1.25.
- Contains twenty-three stories, including *Old Age* and *Doctor*.
- Cost, March: *A MAN NAMED LUKE*. N. Y., Collins, 1933.
- Cronin, A. J. (M. D.): *Y° CITADEL*. N. Y., Bantam, 1937. 50¢.
- Story of the career of a conscientious, brilliant young doctor, from his start in a mining town in Wales, to the realization of his ambition for a London practice. After years of struggle against mediocrity and indifference, he decided to capitalize on personal charm and make money. But success meant forgetting honor and ideals, and brought estrangement from a gallant wife, until a tragic error brought him to his senses. "A restrained but scathing exposé of certain aspects of the British medical profession, which makes a moving and absorbing novel." *Wisconsin Bulletin*.
- Cronin, A. J. (M. D.): *GRAND CANARY*. N. Y., Grosset, 1933. \$1.00.
- With his professional reputation wrecked through jealousy, a London doctor embarks for a trip to the Canary Islands. He is changed by his love for a woman he met on shipboard and whose life he saves in a yellow fever epidemic and he returns to England . . . but to a renunciation and a renewed effort in his profession.
- Cronin, A. J. (M. D.): *Y° GREEN YEARS*. N. Y., Bantam, 1944. 50¢.
- Robert Shannon, who becomes a doctor in the sequel, *Shannon's Way*, first becomes interested in science in this book.
- Cronin, A. J. (M. D.): *Y° SHANNON'S WAY*. N. Y., Grosset, 1948. \$1.00.
- The story of a doctor in his twenties who put his

keen interest in medical research ahead of everything else in life. But he had to face many obstacles, some of which were of his own making.

Deeping, George Warwick (M. D.): *ROPER'S ROW*. N. Y., Knopf, 1929. 365 pp.

Christopher's mother has sacrificed greatly to put him through medical college . . . Chris has suffered, without retaliation, the sneer of his fellow students at his lameness and his difference. Ruth Avery . . . loves the earnest, pale young student . . . After they are married, his success is largely due to her faith and courage. Book Review Digest.

Deeping, George Warwick (M. D.): *Y°SORRELL AND SON*. N. Y., Knopf, 1924. 400 pp., \$2.50.

The story of Kit Sorrell's medical education, seen through the eyes of his father, Stephen, whose sacrifice made it possible.

DeVoto, Bernard: *MOUNTAIN TIME*. Boston, Little, Brown and Company, 1947.

The struggle of Cy Kinsman, surgery resident at Mercy Hospital, New York, to find himself again, after having been "lost". Good description of hospital life.

Dittler, Edgar Leon: *THE HIPPOCRATIC OATH*. N. Y., Liveright, 1938.

Dodge, Mary Mapes: *HANS BRINKER*. N. Y., Winston, 1865. \$1.00.

Dr. Boekmann practices the art as well as the science of medicine.

Douglas, L. C. (M. D.): *°DISPUTED PASSAGE*. N. Y., Grosset, 1939. 432 pp., \$1.00.

Two doctors find their obligation to science more important than their bitter personal feud. The background of the story is a medical school with its hospital.

Douglas, L. C. (M. D.): *DOCTOR HUDSON'S SECRET JOURNAL*. N. Y., Pocket Books, 1939.

Doyle, A. Conan (M. D.): *BOOK OF SHERLOCK HOLMES*. Cleveland, World Publishers, 1891. \$1.75.

Dryer, Bernard (M. D.): *THE IMAGE MAKERS*. N. Y., Harper, 1958.

Dubois, Theodora: *DEATH WEARS A WHITE COAT*. N. Y., Grosset, 1938. 85¢.

A rapidly moving mystery . . . hospital laboratory and an injection which went wrong . . . Some parts may displease the anti-vivisectionists. Wisconsin Bulletin.

Duncan, Norman: *DR. LUKE OF THE LABRADOR*. N. Y., Revell, 1904. 327 pp.

Doctor Luke is a philanthropist, who, putting aside an early career of dissipation devotes his life to relieving distress on the bleak coasts of Labrador . . . A romance full of interest and charm. Independent.
Based on Dr. Grenfell's work in Labrador.

Eberhart, Mignon G.: *THE GLASS SLIPPER*. N. Y., Triangle Books, 1938. 275 pp., 39¢.

This is a mystery-romance of the murders which shook Northside Chicago society, with a background of nurses, doctors and hospitals.

Eberhart, Mignon G.: *PATIENT IN ROOM 18*. N. Y., Grosset, 1929. 302 pp., 50¢.

Murder and radium robbery in a hospital. The suspense is sustained, the action is rapid, but the genuine atmosphere of the hospital and of a lot of thoroughly credible people going through a

harrowing experience is skillfully presented. Saturday Review of Literature.

Eggleston, Edward: *THE FAITH DOCTOR*. N. Y., Century, 1891.

Ekert-Rotholz, A. M.: *°TIME OF THE DRAGONS*, Translated from German by Richard and Clara Winston. N. Y., Viking, 1958. 468 pp., \$4.95.

An absorbing novel, mainly concerned with a Norwegian consul and his three daughters, each of which has a mother of a different nationality. Contains description of medical conditions as Shanghai is occupied by the Japanese, and again by the allies. Chief doctor character is Timothy Williams, a Major with U. S. forces in the Far East.

Eliot, George: *MIDDLEMARCH*. London, Modern Readers, Macmillan, 1872. \$1.00.

Portrays young, enthusiastic Dr. Lydgate, with his plans for a great fever hospital, and detailed background of middle-class life in and near an English provincial town.

Ellis, William D.: *THE BROOKS LEGEND*. N. Y., Crowell, 1958.

Gives a detailed picture of the medicine of the American frontier in the early 19th century.

Eckman, E. and Chatrian, A.: *MADAME THERESE OR THE VOLUNTEERS OF '92*. Translated from French. N. Y., Scribner, 1864. 289 pp.

Madame Therese is a vivandiere whom a country doctor rescues from among the wounded in a skirmish, and nursing her, falls in love. 1792-93.

Fabricant, N. D. and Werner, H.: *A TREASURY OF DOCTOR STORIES*. N. Y., Frederick Fell, 1946.

Fangen, R.: *DUEL*. Translated from Norwegian by Paula Wiking, N. Y., Viking, 1934. 379 pp.

The 'Duel' of the story is the lifelong hostility in the friendship between a country doctor and his brilliant contemporary, a jurist and thinker of international fame. Book Review Digest.

Fearing, Kenneth: *THE HOSPITAL*. N. Y., Random House, 1939. 279 pp., \$2.50.

In short chapters . . . the author traces a few hours in the lives of a group of doctors, nurses, patients, and the maintenance men in a huge hospital. The focal point of the story is the effect upon the great system of the few minutes when the power is turned off by a drunken janitor. Book Review Digest.

Fineman, Irving: *DOCTOR ADDAMS*. N. Y., Random House, 1939. 454 pp., \$2.50.

Lifted out of the ordinary class of medical novels by its range of ideas and its manner of narration. Its study of a biophysicist, the satisfactions he finds in his austere science, the impasse he has reached with his wife, and his later sexual experiences, is really a study in physical creativity. The boldness of some of the episodes, the staggering medical erudition, and the passages told in the stream of consciousness, all keep this from being a book for everybody but it should appeal strongly both to those interested in problem novels and in literary technique. Book of the Month Club News.

Fishwick, Dwight Brown: *WHITE COATS, A STORY OF MEDICAL SCHOOL*. N. Y., Dodd, 1939.

Flaubert, Gustav: *°°MADAME BOVARY*. N. Y., Pocket Books, 1857. 35¢.

Perhaps the most perfect work of realistic art in

- any language; a faithful and infinitely painstaking interpretation of actual life . . . plain history of slow but inevitable moral degeneration of a weak woman.
Flaubert, son and brother of physicians, gives us excellent descriptions of pathological conditions: Hippolyte's club foot, the purulent sores of the blind beggar, the poisoning of Emma.
- Frede, Richard: *THE INTERNS*. N. Y., Random House. 1960. 374 pp. \$4.95.
Story of New North Hospital and its interns. Depicts their struggles to perfect techniques and knowledge, and for the few residencies available to them.
- Furman, Abraham L.: *CONSULTING SPECIALIST*. N. Y., Macaulay, 1937.
- Gervais, A.: *MADAME FLOWERY SENTIMENT*. N. Y., Covici, 1937. 233 pp., \$2.00.
A delightful little story, concerning a love affair between a captivating Chinese lady and a French doctor, told from his angle . . . The two chief protagonists are temperamentally and educationally miles apart . . . Fragmentary episodes sustain the story. Szechwan two thousand miles in the interior of China, still almost untouched by modern progress, forms the background. *New York Times*.
- Gibbs, Willa: *TWELFTH PHYSICIAN*. N. Y., Farrar, Straus & Young, 1954. 277 pp., \$3.50.
A novel about medicine during the French Revolution when hospitals were closed in part and it was prohibited to teach medicine. Dr. Florian, who agrees to teach five students, typifies the doctor's devotion to duty. He lives through many subsequent hazards including banishment to French Guiana and service in Napoleon's Egyptian campaign. H. W. Wilson.
Recommended for mature students because of the rich historical background of the French Reign of Terror, the medical interest, ethical implications, and the holding power of its plot, in spite of the rather forbidding format.
- Gibbs, Willa.: *THE DEDICATED*. N. Y., Morrow, 1960. 224 pp., \$3.50.
Exciting drama of medical discovery, and skillfully drawn picture of England in the late eighteenth century, telling of Jenner and Dr. William Woodville.
- Gordon, Richard (pseud.): *DOCTOR IN CLOVER*. Garden City, Doubleday & Co. 1960.
One of a delightful zany series of doctor stories, by a former ship's doctor, anesthetist and medical journalist, now retired in favor of writing.
- Graves, Robert: *THEY HANGED MY SAINTLY BILLY, THE LIFE AND DEATH OF DR. WILLIAM PALMER*. N. Y., Doubleday & Co., 1957. 312 pp., \$3.95.
A 19th century English scandal, "the case of Dr. William Palmer," convicted of poisoning his best friend—is recast in slightly fictionalized form. The sum of the testimony points unmistakably to the conclusion that Dr. Palmer was an unprincipled rogue; that he was guilty of many crimes, including forgery, adultery, fraud, and malpractice; but that he was hanged after a biased trial, for a murder he had not committed. Booklist.
Readers should be cautioned that there are a couple of gruesome autopsies, and some rather lengthy and boring details of financial finagling. But the whole adds up to an unusual reading experience. *Kirkus*.
- Green, Gerald: *LAST ANGRY MAN; A NOVEL*. N. Y., Scribner, 1957. 494 pp., \$4.50.
The last angry man was a Brooklyn doctor, who for 40 years had lived in the slums, angry at all injustice, carrying on his profession as a general practitioner, believing in medical ethics and living up to his beliefs. A TV studio decided to do the story of his life for a new program, and in the process of setting up the program the story of the life and death of Dr. Samuel Abelman is told. *Book Review Digest*.
- Hall, James Norman: *DOCTOR DOGBODY'S LEG*. Boston, Little. 1940 (*Atlantic Monthly Press Book*)
Ten tales of a seagoing Munchausen, Dr. Dogbody, who was a surgeon for fifty years in His Majesty's Navy.
- Han, Suyin: . . . *AND THE RAIN MY DRINK*. Boston, Little, Brown & Co. 1956.
An intricate story of the many races and cultures mingled in the life of the Malay peninsula. The author, an Eurasian physician, who lives today in Malaya, is very much a part of this life, which she understands thoroughly.
- Hancock, Lucy Agnes: *VILLAGE DOCTOR*. Philadelphia, Macrae Smith Co. 1950.
- Hart, Alan: *DOCTOR MALLORY*. N. Y., Norton, 1941.
Robert Mallory graduated from Medical College with highest honors. In spite of the efforts of his friends to capitalize his brilliance, he went to a bleak little town in Oregon as general practitioner. His battle against ignorance, poverty, and disease went on through the years, and although he lost his wife, his health, and finally his life, he never lost his ideals. *Book Review Digest*.
- Harter, Evelyn: *DR. KATHERINE BELL*. Garden City, N. Y., Doubleday, 1950.
- Hartog, Jan de: *SPIRAL ROAD*. N. Y., Harper, 1957. 465 pp., \$4.95.
Adventure, danger, love and violence all play a part in this novel of doctors and their women in a world of stone-age savagery and brutal vice. The action moves from Batavia, Java, New Guinea and Papua to an awesome climax in a lonely medical outpost deep in the jungle. *Hunting*.
- Hauck, Louise Platt: *THE LITTLE DOCTOR*. N. Y., Grosset, 1936. 75¢.
- Hauptmann, Gerhart Johan Robert: *ATLANTIS*. Translated by Adele and Thomas Seltzer. Cleveland, Hueback, 1912. 415 pp.
The German doctor and the Swedish dancer with their love story formally the connecting link, fade into insignificance in comparison with the broad imaginative view of our complex modern life, as beheld on the vast liner crossing the Atlantic, or in the furious stress of business and pleasure in the U. S.; a view that is essentially critical and philosophical. *Baker's Best*.
- Hilton, James: *WE ARE NOT ALONE*. Boston, Little, Brown & Co., 1937. 231 pp.
Story of a skillful and efficient doctor, a familiar figure in an English cathedral town whose life was shattered because of a German girl he befriended. They were both convicted and hanged on circumstantial evidence for the murder of the doctor's wife. The story is reconstructed years later by one of the doctor's patients. *Ontario Library Review*.

Hobart, Alice Tisdale: *YANG AND YIN; A NOVEL OF AN AMERICAN DOCTOR IN CHINA*. Indianapolis, Bobbs, 1936.

Howells, William Dean: *DOCTOR BREEN'S PRACTICE*. Boston, Houghton, 1881.

Hulme, Kathryn Cavarly: *NUN'S STORY*. N. Y., Pocket Books, 1956. 339 pp., 50¢.

The story is claimed to be truly based on the life of a Belgian girl who became a nun, learned tropical nursing and practiced in a hospital . . . in the Belgian Congo. In Europe after the Nazi invasion her hospital became a sanctuary for the Underground and it was then that she realized the lack of humility which made it impossible for her to continue in the order. *American News of Books*.

Some enlightening vignettes of the disciplines of nursing and missionary orders. Occasional clinical reporting of violent scenes which take place in a mental hospital and a mission station in the jungle may limit the appeal of this semi-documentary. *Booklist*.

Hutchinson, R. C.: *FIRE AND THE WOOD; A LOVE STORY*. N. Y., Farrar and Rinehart, 1940. 440 pp., \$2.50.

Germany and England form the setting of this (tragic) story of a young German scientist who believes that he has discovered a cure for tuberculosis. *Hunting*.

Huxley, Aldous L.: *EYELESS IN GAZA*. N. Y., Harper, 1936. 473 pp., \$2.75.

Story of an intellectual youth beset by doubts and vacillations . . . until he meets an indomitable Scotch doctor in Mexico. Thereafter he fashions his life according to the doctor's pattern and finds a new freedom. *Book Review Digest*.

Ibsen, Henrik: *AN ENEMY OF THE PEOPLE*. N. Y., Scribner, 1882.

Dr. Stockman, the hero of this play, stands out above the petty bureaucrats and self-seeking politicians in the small Norwegian town.

Jewett, Sarah Orne. *A COUNTRY DOCTOR*. Boston, Houghton & Mifflin, 1884.

Johnston, Hamilton: *DOCTOR'S ORDERS*. N. Y., William Sloane, 1958.

Very funny story of a country doctor practicing in suburban England under socialized medicine.

Kantor, MacKinlay: *LONG REMEMBER*. N. Y., Coward-McCann, 1934. 411 pp., \$2.50.

Knittel, J.: *DOCTOR IBRAHIM; A BIOGRAPHICAL NOVEL*. London, Stokes, 1935. 386 pp., \$2.50.

The story of a native Egyptian doctor's career told in the shape of notes for an autobiography. It pictures an idealist's struggles in corrupt environments—first a destitute boy's determination to get an education, then a doctor's efforts to help his people while he is thwarted by incompetence and dishonesty. Long, sometimes tedious, and of interest chiefly for what it reveals of Egyptian life. Ugly incidents are frankly related. *Booklist*.

Lewis, Sinclair: *ARROWSMITH*. N. Y., Modern Library, 1925. \$1.25.

Sinclair Lewis has drawn a full-length figure of a physician, a born seeker and experimentalist. He follows Martin Arrowsmith from medical school through experiences as a general practitioner, as health officer and clinician, as fighter

of the plague on a West Indian Island and finally as director of a medical institute. He marries twice. His first wife is both playmate and helpmate, who ministers to his genius and puts up with his egotism. His second wife, rich and exacting, tries to make him a fashionable scientist, and failing in the attempt, divorces him. The book leaves him in the Vermont woods, working with a fellow-spirit as an independent researcher. *Book Review Digest*.

Lin, Hazel Ai Chun: *PHYSICIANS*. N. Y., Day, 1951.

Lincoln, Joseph Crosby: *DOCTOR NYE OF NORTH OOSTABLE*. N. Y., Appleton, 1923.

McCrone, Guy: *CHARLOTTE AND DOCTOR JAMES*. N. Y., Farrar, Straus, & Co., 1956. 278 pp., \$3.50.

A "story told on two levels, as Margaret Raymond, widow, returns to her childhood home in Glasgow, and—during her beloved doctor grandfather's illness, explores the story of his romance—and finds its parallels in her own." *Kirkus*.

A good story for young and old and an addition to the stories of dedicated physicians. For all collections. *Library Journal*.

McCullers, Carson (Smith): *THE HEART IS A LONELY HUNTER*. N. Y., Bantam, 1940. 50¢.

Set in a southern town. A deaf mute, left without his friend, 'listens' to the stories of several in the town, especially a quick-lunch proprietor, a little girl, an intellectual Negro doctor, etc. *Book Review Digest*.

Mason, Van Wyck: *EAGLE IN THE SKY*. N. Y., Pocket Books, 1948. 50¢.

The young doctors, their careers, love-making, and adventures, dominate the scene. Tale of the two-year period, 1780-81, ending with surrender of Cornwallis at Yorktown.

Maugham, William Somerset (M. D.): *OF HUMAN BONDAGE*. N. Y., Pocket Books, 1915.

Realistic portrayal of the life of a youth handicapped by deformity, whose early life was a process of self-torture . . . plunges deeper into gloom as a lonely lad in London, as a student at Heidelberg, and as a would-be artist in the Latin quarter in Paris. *Pittsburgh*.

Maurois, A.: *WEIGHER OF SOULS*. Translated by Hamish Miles. N. Y., Appleton, 1931.

Medearis, Marv: *BIG DOC'S GIRL*; with a foreword by Maureen Daly. N. Y., Lippincott, 1950. 191 pp., \$2.50.

This is the story of an Arkansas doctor, his daughter and his family, their relations with the "back country" people, the doctor's fight for mosquito prevention, etc.

Melony, Franken (pseud.): *WHEN DOCTORS DISAGREE*. N. Y., Farrar, 1940. 282 pp.

A woman doctor is faced with two problems, how to overcome masculine prejudice and what to do about the instinctive urge toward wifehood and motherhood within her. A drama of hospitals and operations.

Mergendahl, Charles: *THE BRAMBLE BUSH*. N. Y., Putnam, 1958.

Dr. Guy Montford's medical integrity is well-portrayed.

Mitchell, Silas Weir (M. D.): *DOCTOR NORTH AND HIS FRIENDS*. N. Y., Century, 1900.

O'Brien, Kate: *THE ANTEROOM*. Garden City, Doubleday & Co. 1934.

Oemler, Marie (Conway): *JOHNNY REB, A STORY OF SOUTH CAROLINA*. N. Y., Century, 1929.

O'Hara, John: *THE DOCTOR'S SON*. N. Y., Harcourt, 1935.

O'Hara, John: *FAMILY PARTY*. N. Y., Bantam, 1956. 25¢.

At a testimonial dinner in honor of Dr. Samuel Merritt of Lyons, Pa., the principal speaker tells "of Sam's boyhood and early years, his forty years of unselfish service as doctor and friend to the whole community, his hobbies and unstinting helpfulness (and) then unexpectedly reveals the truth about Sam's dream of a local hospital." Kirkus.

Pasternak, Boris Leonidovich: *DOCTOR ZHIVAGO*. Translated by Max Hayward and Manya Harari. N. Y., Pantheon Books, 1958. 558 pp., \$5.00.

This story is in the tradition of the great Russian novel, but it is not a medical novel. The hero could just as well have been the poet that he is, and not a doctor.

Pinckney, Josephine: *HILTON HEAD*. N. Y., Farrar, 1941.

Based on the actual adventures of a young surgeon who went to Carolina from England by way of Barbados. (1665-1686)

Rabelais, Francois (M. D.): *GARGANTUA AND PANTAGRUEL*. Translated by J. M. Cohen. Baltimore, Penguin, 1956. \$1.50.

Contains much of the medical learning of the age, and the satiric spirit of an era made great by Thomas Linacre, Paracelsus, Vesalius, and de Vinci.

Remarque, E. M.: *ARCH OF TRIUMPH*. N. Y., Grosset, 1945. \$1.49.

Paris, prior to German occupation. Novel setting around Ravic, a famous German refugee surgeon, and Joan Madou, a singer and actress . . . just as a story it is completely absorbing; but beyond that it is in a profound sense educational. It gives us a glimpse of what the Germans have made out of Europe. Book of the Month Club News.

Rinehart, Mary Roberts: *THE DOCTOR*. N. Y., Farrar & Rinehart, 1936.

Robinson, Alice M.: *THE UNBELONGING*. N. Y., Macmillan, 1958.

Small but impressive book, concerning Bill Goodman, the young, sincere doctor, and Laurie Hammond, his patient.

Rodney, George Brydges: *MAVERICK MEDICO*. Toronto, Ryerson Press. 1941.

Rogers, Cameron, and Halland, Herman E.: *FLIGHT SURGEON*. N. Y., Duell, 1940.

Russell, Sheila MacKay: *A LAMP IS HEAVY*. Illustrated by Jean McConnell. N. Y., Lippincott, 1950. 257 pp., \$3.00.

. . . the excitement behind the scenes of hospital activity is highlighted in the story of Susan, a student nurse.

Rutherford, Gay: *THE NEW DOCTOR*. N. Y., Phoenix, 1941.

Sangster, Margaret Elizabeth: *SURGICAL CALL*. N. Y., Greenberg, 1937.

Seifert, Elizabeth: *LOVE CALLS THE DOCTOR*. N. Y., Dodd, Mead, 1958.

Latest story by Mrs. Seifert, and one of the better ones.

Seifert, Elizabeth: *THE DOCTOR'S HUSBAND*. N. Y., Crest Books, 1957. 35¢.

Seifert, Elizabeth: *DOCTOR WOODWARD'S AMBITION*. N. Y., Bantam, 1945. 25¢.

Skidmore, Hubert: *HILL DOCTOR*. N. Y., Doubleday, 1940. 307 pp., \$2.50.

York Allen is back in the Blue Ridge district again, a full-fledged doctor. Unscrupulous timber agents have prejudiced the hill people against new methods and young Dr. Allen has a battle on his hands. In *River Rising*, first of the series, York worked in lumber camps here to earn money for his medical education.

Slaughter, Frank Gill (M. D.): *DAYBREAK*. N. Y., Doubleday, 1958. 320 pp., \$3.95.

One of the author's better books, this disseminates sound information on mental health in a romantic form that will recommend it to the less discriminating reader. Booklist.

Slaughter, Frank Gill (M. D.): *DIVINE MISTRESS*. N. Y., PermaBooks, 1949. 35¢.

Novel of the search for truth by a doctor (Servetus) in the days of the Spanish Inquisition.

Slaughter, Frank Gill (M. D.): *GOLDEN ISLE*. N. Y., PermaBooks, 1947. 35¢.

Slaughter, Frank Gill (M. D.): *ROAD TO BITHYNIA: A NOVEL OF LUKE, THE BELOVED PHYSICIAN*. N. Y., Doubleday, 1951.

Slaughter, Frank Gill (M. D.): *THAT NONE SHOULD DIE*. N. Y., Doubleday, 1941. 423 pp., \$3.00.

The story of an idealistic young surgeon who sets out to fight some conditions in the world of medicine and some of the accepted ethics in the profession.

Soubiran, André: *THE DOCTORS*. Translated by Oliver Coburn. N. Y., Putnam, 1953. 441 pp., \$3.95.

The life of a group of medical students in Paris and one in particular who finally decided to settle down to the serious task of becoming a doctor and to the love of one woman. Publisher's Weekly.

This frank and realistic European novel, reflecting the problems, temptations, ideals and personalities peculiar to the medical profession, will appeal to serious readers interested in medicine rather than to readers of light fiction.

Soubiran, André: *THE HEALING OATH*. Translated by Oliver Coburn. N. Y., Putnam, 1954. 376 pp., \$3.95.

This story follows its hero from medical school to a rural region of France; there, under the example of a fine country doctor for whom he gains respect to recover his jarred faith in his profession.

Southern, Terry: *FLASH AND FILIGREE*. N. Y., Coward-McCann, 1958.

A comic novel; sharp and funny take-off on a give-away panel show entitled "What's My Disease?"

Stolz, Mary (Slattery): *HOSPITAL ZONE*. N. Y., Harper, 1956. 205 pp., \$2.50.

The story of Honey Kirkwood, an nineteen-year-old student nurse—many different people with

whom she comes in contact—both in and out of the hospital zone.

Swinerton, F. A.: *THE DOCTOR'S WIFE COMES TO STAY*. N. Y., Doubleday, 1950. 305 pp., \$3.00.

Rex Tweed, London portrait painter, probes the character and married life of his mother-in-law. . . . Bit by bit he discovers much about this woman who married the straight-backed gruff Dr. Anderson.

Taylor, Robert Lewis: *TRAVELS OF JAIMIE MCPHEETERS*. N. Y., Doubleday, 1958. 544 pp., \$4.50. Pulitzer Prize, 1958.

Dr. McPheeters, and son Jaimie, go to California in 1849. "Piquant combination of solid historical content, satisfying adventure, good literary style, sophisticated wit and humor, will give this book wide appeal."

Thompson, Morton: *THE CRY AND THE COVENANT*. N. Y., New American Library, 1949. 50¢.

A novel based on the life of . . . Dr. Ignaz Semmelweis.

Thompson, Morton: *NOT AS A STRANGER*. N. Y., New American Library, 1954. 75¢.

From childhood on Lucas Marsh was interested in only one thing: the practice of medicine. This story tells of his life from medical school days through his experiences as a small town practitioner. It tells also of how he came to see his patients not as cases but as human beings.

Thompson, Thelma: *DOCTOR RED*. N. Y., Arcadia, 1941.

Trollope, A.: *DOCTOR THORNE*. N. Y., Everyman's Library, 1858. 506 pp., 95¢.

Through the lives of Dr. Thorne and his niece, Mary, we learn how several doctors lived and worked in western England, about 1854.

Truax, Rhoda: *HOSPITAL*. N. Y., Dutton, 1932.

Tucker, Augusta: *THE MAN MISS SUSIE LOVED*. N. Y., Harper, 1942. 510 pp.

The heroine, Miss Susie, falls hopelessly in love with Chris Beverly, who dies a victim of the inadequacies of medical knowledge . . . From that moment, her life was tied to the building of the great hospital which was to bear the name of its donor, Johns Hopkins.

Tucker, Augusta: *MISS SUSIE SLAGLE'S*. N. Y., Harper, 1939. 332 pp.

For twenty-seven years Miss Susie kept a boarding house near Johns Hopkins and mothered the medical students of two generations. This is the story of one group, hardworking earnest students, somewhat ribald, but sentimental about Miss Susie and awed by the great men who are making medical history. The time is the (First) World War period, and the novel is dated, but it will please readers who enjoy details of operations,

accidents, and autopsies, lightened by several romances. Booklist.

Turner, Lida Larrimore: *MULBERRY SQUARE*. Philadelphia, Macrae Smith Co. 1930.

Walker, Mildred: *DOCTOR NORTON'S WIFE*. N. Y., Harcourt, Brace & Co., 1938. 269 pp.

Through the eyes of Sue, recently invalided wife of Dr. Norton, professor in a midwestern medical college, we see the lives of young research men and their families.

Walker, Mildred: *MEDICAL MEETING*. N. Y., Harcourt, Brace, 1949. 280 pp., \$3.00.

Dr. Henry Baker and his wife, Liz, have discovered a mold antibiotic successful in curing 25% of the TB patients upon which it is tried. Liz learns at this Chicago medical meeting that the test upon their daughter has, while it saved her life, resulted in her deafness.

Waltari, M. T.: *THE EGYPTIAN*. N. Y., Pocket Books, 1949. 50¢.

Set in Egypt, more than 1,000 B. C., it encompasses all of the then-known world. It is told by Sinuhe, physician to the Pharaoh, and is the story of his life. Through his eyes are seen innumerable characters, full drawn and covering the whole panorama of the ancient world.

Weenolsen, Hebe: *TO KEEP THIS OATH*. N. Y., Doubleday, 1958.

Excellent historical novel about 12th century England and Wales under Norman rule. Protagonist is Father Peter-Paul, a priest-physician who cares for the Welsh miners.

Wells, H. G. (M. D.): *ISLAND OF DOCTOR MOREAU*. N. Y., Ace, 1906. 35¢.

Wingate, Peter, (M. D.): *DOCTOR TOM*. N. Y., William Morrow, 1958.

Light medical novel on practice of medicine in primitive Africa; realistic, excellent.

Yerby, Frank: *THE SERPENT AND THE STAFF*. N. Y., Dial, 1958.

Unevenly written. Dr. Hans Volker is the idealistic doctor in the story.

Young, Francis Brett: *DOCTOR BRADLEY REMEMBERS*. N. Y., Reynal, 1938. 522 pp., o. p. 1950.

After half a century of service, a doctor tells the story of his long and busy life. "Loses a little from the retrospective form in which it is cast, but novels about doctors can hardly help being interesting." *The New Yorker*.

Zweig, Stefan: *BEWARE OF PITY*. N. Y., Viking, 1939. 498 pp.

of Europe". This is his first full-length novel. "There are two kinds of pity", says the author . . . he shows what these two kinds may do for good or evil. *Book Review Digest*.

SIMPLICITY IN MEDICAL WRITING

JOHN J. RAINEY, M. D., F.A.C.S., F.I.C.S.

Troy, New York

There has always been a need for the concise and simply written medical paper. This, however, is not as simple as it seems, because the moment the physician puts pen to paper he is no longer the plain-spoken, kindly practitioner of the art of medicine, but an entirely different person. He becomes ultra-scientific and on occasion may find himself in a miasmatic labyrinth of gobbledygook. Chesterton's advice—"To write simply is the essence of good English"—is easily forgotten.

It is not necessary to begin with the statement that the subject is interesting. It is up to the writer to prove that. It is best to begin with a brief statement as to what it is all about, and then get on with the subject matter.

Historical asides should be brief and not put in the introduction. Several paragraphs farther on, if the reader is tiring, a well written, compact bit of history may stimulate his interest.

The observation that the scientific knowledge of the ancients was obscure has no place. Everyone knows that, and no apology need be made for men of bygone ages, who in some respects were better observers than the physicians of today. They possessed the virtue of presenting their thoughts briefly and clearly.

Bibliographic data are always dreary furniture. It would be well to keep the number to a minimum.

The conclusion should bring into focus all that has gone before. It is a recapitulation and should paint an unforgettable word picture. If this is done, the author may be reasonably certain that the reader will then start at the beginning and read the entire article. No greater compliment could be paid any man.

During the past few years something macabre has been adopted by the dilettante lay journals and by some strange mystery is now found in medical journals noted for their purity and austerity. It is the strange symbol "and/or." Here is the greatest cerebral road-block ever contrived, and at this point the brain reels and the article makes quick passage to the limbo of forgotten things.

Has supplied all writers with a terse reminder that medical authors might well heed:

Walter Savage Landor
Never used *and/or*.

In the New York Times, Jacques Barzun writes that Sir Ernest Gowers is a retired British Civil servant whose father, as a young physician, discovered the knee jerk. The son grew up to hear this called the patellar reflex. He was a lifelong official of the treasury, and he witnessed many more changes of the familiar into the unspeakable. In 1948, Gowers wrote by request a small book called *Plain Words*. Three years later he added a glossary, *The A B C of Plain Words*, and today it is a best seller. His name now is a common verb. To "Gowerize" in England

means to translate the vulgar "patellar reflex" into the simple, aristocratic elegance of "knee jerk."

Gowers' crusade should be heeded by all. If ever there came a time for reform it is now. Instead of adding new variations to medical and surgical jargon, we should get down on our knees and start weeding. For example, 12,000 new terms have been added to the new Gould Medical Dictionary.

In addition to the new terms, 8,000 old ones have been rewritten. The physician is bewildered and bedeviled by all this and is beginning to wonder at just what point he will lose contact with the English language and find it necessary to employ an interpreter to keep in touch with his patients.

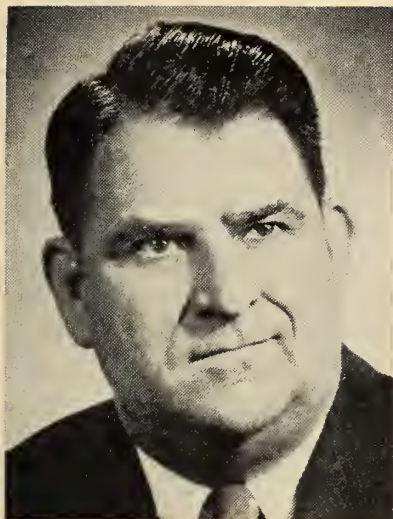
The overuse of certain words seems to run in cycles. A few years ago the word "evaluate" was found in every other paragraph. At medical meetings, if the speaker was positive and powerful of voice, it sounded like Gabriel's last trump. The two-syllabled "assess," more direct and euphonic, was forgotten. "Reversible" and "irreversible" are now getting quite a play in medical writing and discussions.

The chief current horror at the moment, however, is the substitution of "mitigate" for "militate." Like all other such assaults upon the language, this is spreading like a forest fire. "The employment of this type of surgical procedure mitigates against early recovery," says the author innocently, having heard the expression at the latest scientific meeting he has attended, and hundreds of others instantly pick it up.

Another linguistic microbe that has got in somehow and seems likely to cause an equal epidemic: the use of "amendable" for "amenable." In the first place this was probably an error made by the author's typist and overlooked by him; but no matter, it is as violently contagious as chickenpox or pinkeye. True, these diseases are not confined to medical publications; only a few days ago a report in one of our major magazines came out with the statement that several hundred acres of farm land in the South had been *liquidated* by the recent floods. This, however, does not excuse the continuous and increasing incidence of such symptoms among those whose task it is to heal diseases, not spread them.

Every passing year sees at least fifty of these misbegotten words and phrases, the parvenus of language, usurp the places of their betters. Meanwhile, the old gate-crashers are still with us; redundancy (*red in color, square in shape, soft in consistency, pathologic in nature*); misdefinition (*pathology for lesion or disease, surgery for operation, case for patient*) ("this case was tightly bandaged and early next morning gave birth to a healthy child"); grammatical torts and malfeasances (a contrast media, this data, one criteria); hamstrung syntax ("cerebral palsied cleft palate and harelip patients"); verbosity—or, if the verbose prefer, logorrhea ("the pathological findings present were associated with an additional pathology indicating the presence of a possible post-meningitic

(Continued on page 548)



President's Pages

THE FOLLOWING IS PART OF A SPECIAL REPORT TO ALL DELEGATES CONCERNING RE-REGISTRATION:

In 1959 in a recommendation made to our Council by the South Carolina State Board of Medical Examiners, it asked that our Association endorse a bi-annual registration of physicians licensed to practice in South Carolina. Various reasons were given by the Board, and it appeared that such a law would help materially in its administration of the Medical Practice Act.

Council concurred and recommended this to the House of Delegates when it met in Columbia in 1959.

After this had been referred to the Reference Committee and thoroughly discussed there, it was given a favorable report and adopted by the House of Delegates at that time. At the same time our Committee on Legislation was instructed to bring before the House of Delegates the next year a proposed bill which would legalize re-registration when passed by the General Assembly. This bill was to be approved by the House of Delegates before it was submitted to the State Legislature.

Accordingly, the Bill was submitted to the House of Delegates at Myrtle Beach, in this year's Session (1960). At that time it caused considerable discussion and debate, and was passed by a majority of the House of Delegates. However, it was not a unanimous decision.

Since this last meeting of the House of Delegates, there has been considerable discussion concerning re-registration by physicians over the state, and I have received letters from several County Medical Societies concerning this. Several of the societies have gone on record as opposing this action and asking that it be reconsidered. Several of the societies have reaffirmed their desire to go along with the action which the House of Delegates has already passed by a majority vote. I have received 21 letters from individual delegates requesting that before this bill is sent to the State Legislature that it be reconsidered by our House of Delegates.

As your President it is my duty to carry out the mandates of the House of Delegates to the best of my ability and in accord with my best judgement. Therefore it would seem that the bill in question should be presented to the State Legislature, with the request that it be passed into law. However, as your President I also have what I consider a higher duty, and that is to protect the unity and welfare of our State Association.

Because of the opposition which has been voiced recently concerning this re-registration, and because of the very practical fact that any legislation of this sort, if introduced into the Legislature without our united support will undoubtedly be opposed—I have, after consultation with Council, arrived at the following conclusions:

- (1) From a practical standpoint it does not seem that our State Legislature would permit itself to pass any law affecting the medical profession in South Carolina unless it had full and unqualified support from the Association itself.
- (2) Even if they were inclined to pass such a law at the request of the State Examining Board, the division within the Society itself would of necessity show up during the discussions within the Legislature, and our Medical Association would suffer in the eyes of the public as being unable, or unwilling, to reach unanimity of opinion. This could be construed only as very poor public relations.

On the basis of these considerations it has been decided that the bill in question should not be presented to the Legislature during this Session but should await further discussion and clarification, and be reconsidered at the regular House of Delegates meeting which is to be held in April of this year. No special meeting will be called.

• • • • •

The following are the answers to many questions which have been asked of me during

this discussion on re-registration. These questions have been answered by referring to the published record as appearing in our *Journal*, and by consultation with different members of the State Board of Medical Examiners. The answers are unbiased, and are an attempt to answer as well as I know how. It is hoped that these questions and answers will help you to understand the problem of re-registration a little better the next time that we discuss it.

1. Why should a doctor have to be re-licensed every 2 years?

Ans. This is an erroneous assumption. The Bill says he must *re-register*—not be *re-licensed*. Any doctor in good standing with the Board on re-registration day will be automatically re-registered on payment of the fee, along with the completed re-registration form.

2. What is the wording of the bill to be introduced?

Ans. Every person heretofore or hereafter licensed to practice medicine and surgery by the State Board of Medical Examiners, shall, during the month of January, 1962 and during the month of January of every even numbered year thereafter, register with the Secretary-Treasurer of said Board, his name, office and residence addresses, and such other information as the Board may deem necessary and shall pay a registration fee fixed by the Board but not to exceed five dollars (\$5.00). In the event a physician fails to register as herein provided, the Board may at its discretion levy a penalty of an additional fee. Should a physician fail to register and pay the fees imposed, and should such failure continue for a period of thirty days, the license of such physician may be suspended by the Board after due notice and hearing at the next regular meeting of the Board. Upon payment of all fees and penalties which may be due, the license of any such physician may, at the discretion of the Board, be reinstated.

Note: It is agreeable with the Board to change the last sentence to read “. . . the license of any such physician *shall* be reinstated.”

Also, the Board would consider any reasonable change in wording which would not emasculate the bill.

3. When was this bill passed by the S.C.M.A.?

Ans. Re-registration has been discussed for several years as being of merit and worthy of our consideration.

First passed in principle in Columbia in 1959. Reaffirmed at Myrtle Beach in 1960.

4. Why was it necessary to go before the House of Delegates twice?

Ans. Action in 1959 instructed that a suggested Bill be presented for approval by the House before it would be introduced. The above Bill was submitted and approved this year at Myrtle Beach.

5. Was the Bill fully discussed at these times?

Ans. Yes. The Minutes of these meetings found in September, 1959 Issue of the Journal on page 369 and in September, 1960 issue, page 384, show the discussions and motions of the deliberations.

6. What benefit will the Board derive from this Bill?

Ans. It will keep an accurate list of all doctors licensed by the Board to practice in South Carolina. This would include in addition to members of the South Carolina Medical Association, also those doctors who do not belong to County Medical Societies and, also, those practicing in other states or out of practice at the present time.

7. How will this affect the Board and the people of South Carolina?

Ans. It will allow a continuous check on those people who now practice out of state, or who are not in practice, who could return to practice in South Carolina at any time since they have already been issued a license. If these people have been unethical practitioners in their present location, or had committed crimes, etc. the Board would already know and would have acted before the person committed the same offense a second time, thus protecting the public welfare.

8. Doesn't the function of censorship already fall within the purview of the County Society?

Ans. Yes. So far as their own members are concerned. The Board will rely on information from the various counties concerning their members. Also, it will at times request their cooperation concerning information about non-members. However, it is evident that this would have to be passed on to a higher agency, in this case the Board, since the counties are without jurisdiction over non-members. Similarly, the County Society in other states would be the source of information concerning the doctors who do not live in South Carolina. When the re-registration report so indicates, a direct inquiry to the local Society will be made in order to keep the file up to date.

9. Would the Act give the Board more power? Wouldn't it become somewhat of a “gestapo”?

Ans. The Board already has broad power. It has full authority to regulate medical practice in South Carolina. This amendment would simply make it easier for the Board to do its work and make for more satisfactory method of safe-guarding the public welfare against unethical people.

10. What will the \$5.00 be used for?

Ans. Expenses, consequent to re-registration, which would include publishing a list of all doctors who are licensed to practice in South Carolina.

11. Would not such a list be a duplicate of our present directory published by the South Carolina Medical Association?

Ans. No, since this directory would include, in addition to members of the South Carolina Medical Association, also those M. D.'s in the State who do not belong to the South Carolina Medical Association, and also those who reside without the State.

Note: It has been suggested to the Board, and favorably received by them, that such a directory might be issued in conjunction with the directory published by the S. C. M. A., and include in an addendum the names of those practitioners not members of the Association, and those licensed but

who practice out of state. By prorating the cost of such a directory it would save the Association money and also cut down on this proposed expenditure, thereby allowing more money to accumulate in their Investigation Fund. The S. C. M. A. is already charged with endeavoring to keep a list of all physicians, whether members of the Association or not. This is spelled out in our Constitution. This list has been compiled and is on file with our Executive Secretary; however, it is a tremendous job to keep it up to date, and would certainly be facilitated if this list could be certified at regular intervals by the State Examining Board.

12. Suppose the \$5.00 is more than enough to finance this? Would we get a refund?

Ans. No. It is hoped that a small surplus will be realized so that the Board could use it to investigate unethical practitioners, both in this state and out of the state when circumstances would deem necessary. The present budget of the Board is far too small to accomplish this at the present time.

13. What would be the danger to our present medical practice act if such an amendment were offered in the State Legislature?

Ans. None. The amendment is very simple and would in no way jeopardize our present act.

Since it is the prerogative of any Legislator to offer a bill amending our Medical Practice Act any time he so desires, it is at present and always has been, subject to this danger if anyone should choose to attempt to modify it. This is true whether or not they had our consent. It is likewise true that without our consent any such amendment would have a very slim chance of passing.

The only way which the present amendment would change the situation would be that since we would presumably be supporting this amendment it would give a lever for compromise to anyone who wished to propose another amendment which we did not like. In this case, if we could not beat down the other amendment it would be up to us to drop this amendment which got us into the compromising situation to begin with.

However, it has been the experience of our Medical Society that whenever we ourselves are in agreement we have nothing to fear in so far as State Legislation is concerned. It is only when we are split up among ourselves that Legislation can become dangerous.

14. If the Act can be amended without approval of the Medical Association, why are we asked to approve the amendment?

Ans. Because the Board of Medical Examiners, although a state agency, still is made up of members of the South Carolina Medical Association, and its members were nominated by it. It has always been the policy of the Board to cooperate with the Association, and always will be. An issue such as this must be wholeheartedly backed by the Association in order to get results, not only in its original passage but also with the administration of the Act after it is passed. The Board also recognizes the very practical assumption that for passage of Legislature it must have the undivided backing of the people most affected by the Act. Also, to go to the Legislature with a problem in which the Association is not in full agreement, the resulting bickering among ourselves will tend to weaken the Association in the eyes of the public.

15. Do other states have re-registration?

Ans. Yes. 44 other states have this type of re-registration. It is hoped that soon all states will adopt this so that a full program of cooperative reciprocity concerning this information will be made available and will strengthen the medical practice acts of all the states.

16. Is this Dr. Jervey's pet bill?

Ans. No, it is true that Dr. Jervey, in his position as President of the Federation of State Medical Boards, has had the opportunity to see the advantages of this in other states and, as Secretary of the South Carolina Medical Examining Board, he is thoroughly in agreement with the request of the Board for its approval but he does not have any personal or pecuniary interest of any sort whatsoever.

Next month the rest of this report sent to the Delegates will be printed, which will suggest ways of keeping up with the various issues to be discussed at the House of Delegates.

YES, VIRGINIA, THERE IS A SANITY CLAUSE

'Twas the Issue for Christmas
And all thru the Journal
The silence was rent with groans most infernal
For the layout was pasted up firmly with care
But no editorial comment was there.
And Joe in his shirt sleeves
And minus a tie
Was scribbling madly as deadline drew nigh
When out in the hallway arose such a clatter
He sprang from his desk to see what was the matter.
Away to the doorway he wearily trod
To plead for a small bit of silence, by God!
When what to his wondering eyes should appear
But the full S.C.M.A. awaiting him there.
Their eyes how they twinkled; their smiles were so sage
And some brought a piece for the Editor's Page
While others (and this is the part that's terrific)
Had duplicate copies of gems scientific.
They had book reviews, abstracts, and case histories
The typed sheets they carried were thicker than fleas.
Each picture was glossy; each reference right
The Editor grinned to show his delight.
As he pinched himself to be sure it was true,
A voice said, "We'll do this each issue for you;
No more last minute phone calls; no tearing of hair
We'll fill all the pages — You just take it from there!"
And laying their fingers aside of their noses
They left to consult on a case — of Four Roses.
But I heard Joseph call as they drove out of view,
"Merry Christmas, you all — Wait — I'm coming too!"

The Editor's Secretary

Editorials

Merry Christmas



*from
the*
EDITORIAL
STAFF

GENERIC NAMES

The arguments for and against the use of generic names continues to flourish, being promoted on one side by the manufacturers who wish to encourage the use of brand names and being sustained on the other side by those who believe that the use of generic names might effect a considerable saving in cost of prescriptions. There is a great deal of talk and a great deal of writing, and the physician now receives a considerable stack of "literature" from the manufacturing houses.

One of these brochures makes the point that prescription by generic names would amount to very little actual saving in cost to the patient, perhaps 12% or approximately one or two cents a tablet or forty or fifty cents for the amount of the drug used during an ordinary acute illness. It points out further that large established and recognized manufacturers maintain careful check of the potency and purity of their products whereas the casual manufacturer, by avoiding such effort, can charge less for his product and still make a satisfactory profit. It seems reasonable that these established companies have reached their level of reputation by producing pure and satisfactory drugs for a long period of time. They have also contributed tremendously to research in the discovery of new compounds and new combinations, and even though the profit motive cannot be disregarded it should be accepted that their intentions have been basically honorable and scientific.

It seems to them that much of the current hullabaloo produced by the Kefauver Committee has no importance. Most people are willing to pay a little more for a reputable brand product, whether it be a suit of clothes, a dishwasher, or a drug. The premium is worth the difference in substance.

In the heat of argument over this question, no one seems to take into very much account the confusion which is created in the minds of the doctor by these innumerable brand names. The doctor is confused not only by the advertising, but he is further disturbed by the use in the medical literature of a number of different names which all mean essentially the same thing or refer to the same basic drugs. The confusion is not only in the minds of the

individual reader, but extends in an aggravated degree to those who have to catalogue in the Index the thousands and thousands of articles which appear, and with the production of every new drug they do appear in aggravated quantity. The medical student is likewise misled into thinking that one brand name is the only reputable name which he may use for a product which may be produced in just as good quality by several other pharmaceutical houses. Fortunate for the manufacturer who can make his brand name stick in the minds of the students and house staffs of our hospitals!

To us the solution still seems to be fairly simple, and it has been advocated many times, and that is to use a combination of the manufacturers' name with the generic name of the drug, so that one can prescribe Muligatawney's prednisolone or Wordenbacker's tetracycline and still thereby attribute all the integrity to the generic name which the manufacturer's name implies. So far no great popularity has attached itself to this suggestion.

INFLUENZA IMMUNIZATION

Practitioners and patients frequently take somewhat divergent views on the question of the value of routine influenza immunization efforts. Individuals swear that protection obtained has been complete, others doubt that they have had much benefit from repeated efforts at immunization. Physicians seem to adopt a rather firm position in one direction or the other.

It is not likely that one would get a reliable statistical evaluation from individuals, and all information at present seems to indicate that the use of currently available vaccine is not worthwhile for the general population except in the face of an identified epidemic of influenza caused by a strain of virus which can be included in the vaccine. However, the Public Health Service offers some very interesting information and urges that as a result of recent experience certain groups of the population be given such protection as the vaccine affords in an effort to reduce a rather large mortality. During the two outbreaks of influenza which occurred in the fall of 1957 and the winter of 1958, there were 60,000 more

deaths than would be expected under normal conditions; and even during the first three months of 1960 there were 26,000 excessive deaths over the normal expectation. The Asian strain of virus was held responsible for this very considerable mortality and seemed to produce serious disease not only in the total population but most markedly among the chronically ill, the aged, and pregnant women. These three high-risk groups are considered to be eminently suitable for the routine use of the vaccine, and the Service notes specifically the following conditions occurring at any age as being indications for the use of the vaccine: rheumatic heart disease, other cardiovascular disease, chronic broncho-pulmonary disease, diabetes, and Addison's disease.

No one has been bold enough to claim that the vaccine is universally adequate. Current evaluation indicates that it is from 60 to 75% effective in preventing the disease. Side reactions are not serious, and the only precaution is in avoiding the use of the vaccine in people who are definitely allergic to egg. Seven reputable pharmaceutical houses are manufacturing the vaccine, according to an approved formula.

While it is preferable to have the vaccine administered well before the onset of colder weather, (preferably no later than September 1st, it would seem that in the absence of any immediate threat of epidemic influenza that it would still be worthwhile to promote the vaccine for all of those people who fall into the groups indicated above.

CLINICS IN ELECTROCARDIOGRAPHY —FROM JOURNAL TO BOOK

It is not very often that material published in *The Journal* achieves book form. Not too long ago Dr. Guess' *History of the Greenville County Medical Society* went through this process to the gratification of *The Journal*. Now *The Journal* can feel pride again in seeing some of its monthly offerings collected into the more permanent and dignified form of a book.

Under the head of Medical College Clinics the Electrocardiogram of the Month has appeared regularly for some time. It has been contributed by Dr. Dale Groom of the Medical

College and has met with apparently pleasant reception. These individual illustrations of currently accepted concepts in interpretation of electrocardiograms are of considerable interest to anyone who deals with the heart. With some slight revision, they have been included in a modest book of 152 pages which has been published by Charles C. Thomas and has just appeared recently. The editor of *The Journal* is happy to have had some small part in the publication of these interesting reports, and wishes the book every success.

ALAS POOR MILTOWN

From a reliable medical publication comes the following statement: "Although meprobamate in large doses may be useful in the treatment of some psychotic patients, prior to the earlier review not one controlled study had shown smaller doses of the drug to be superior to a placebo in the treatment of neurotic disorders. Its 'tranquilizing' effects appeared to be no better than or different from those of a barbiturate. A number of controlled studies have since appeared and several of these do show meprobamate to be superior to placebos in the relief of neurotic anxiety and tension. During this same period, however, a number of other controlled studies have shown no difference in effectiveness between meprobamate and placebos in patients with various neurotic disorders, including children with behavior problems. . . . The evidence of various controlled studies on meprobamate is clearly conflicting. Nevertheless, in the totality of studies available in the literature, including both the new data and the data reported in the review by Lateis and Weiss, *Medical Letter* consultants do not find convincing evidence that meprobamate affords any distinct advantage over appropriate doses of the barbiturates either as a hypnotic or as a daytime sedative for the relief of neurotic anxiety or tension."

THE SCIENTIFIC PRACTITIONER

One of our local contemporaries, in giving the life history of a guest speaker, says: "Dr. _____ spent 25 years in the private practice of _____, during which he was able to maintain scientific interest in the sub-

ject." While this is probably meant to indicate that the practitioner carried out active scientific work in addition to conducting his practice, it rather suggests that a practitioner generally loses his concern for the scientific aspect of medicine in the routine of his daily work. If that is so, then the practitioner becomes a man working by rule of thumb and impervious to the current vital developments in the burgeoning field of discovery. Let us pray that he does not fall into this slough of scientific despond, and that he cherishes science from the beginning to the end of his practice.

DR. GILMORE RESIGNS

The Journal notes with regret that Dr. Harold Gilmore of Nichols, who has been editor of *The Pee Dee Bulletin* for some time has found it necessary to resign from his position. *The Journal* staff has always looked forward to the arrival of *The Bulletin* and has always braced itself for those products of "The Hen's Nest" particularly.

The Journal wishes the best of everything to Dr. Gilmore in his editorial retirement and offers its best wishes to Dr. Ira Barth who is to assume the editorial chair.

Correspondence

Dear Dr. Waring:

The organizing men of South Carolina medicine have offered opinions recently that have outraged me. At the Convocation exercise at the Medical College of South Carolina, Dr. Joseph P. Cain, the president of our State Association is quoted in *The News and Courier* as follows "It is a great temptation for a young professional man burdened by debt and self sacrifice during his training years, to let his enthusiasm for high fees over run his good judgment". The implication of this statement is obvious—few, some, many or all young professional men are enthusiastic about high medical fees; and their enthusiasm obviates their good judgment; and therefore, they charge high fees. Balderdash! These seem formidable words to be addressed to students; some embarking upon, and others finishing, a four-year course in a graduate school. During the entire time of this four-year educational period there will never be a discussion of the economic aspects of medicine. This is not necessarily defensible but as concerns the curriculum of the Medical College of South Carolina, there is no allusion to economics in medical practice. That the statement might serve as food for thought for some of the students is good. That it should have been said at all upon such an occasion is quite debatable. I consider myself a young man in medicine. I must confess that the statement as quoted above provokes revulsion.

Dr. W. A. Hart in *The Recorder* of September, 1960 quotes from the U. S. Department of Labor, Bureau of Labor Statistics, "that increases in physicians fees during the past twenty years have been less than the increase for most other services". "From 1938 to

1958 physicians' fees increased 83.9 per cent". But look what happened to fees for some of the other services during that period; domestic service up 278.9%, men's hair cuts up 207%, shoe repairs up 152.4%, laundry service up 115.2%, transportation up 95.4%, automobile repairs up 93.9%. It would seem more prudent on the part of our president that he take a discussion of medical fees before County Medical Societies if he feels that fee excesses are a problem in the State. It hardly seems worthwhile to belabor students, who have had no introduction into the economic life in medicine, with incendiary statements that young professional men are guilty of charging exorbitant medical fees. Perhaps Dr. Cain plans such visits to County Medical Societies in the future, and a discussion of these problems. I can assure him that I, as an individual, will welcome his visitation before our local medical society.

If Dr. Cain knows of exorbitant medical fees being charged by the young surgeons of my community, (and I can speak only as a surgeon) then I should be happy to give him parallel examples of exorbitant fees charged by those considered as older men in the profession. Some of these gentlemen would be of Dr. Cain's generation or older.

As an occasional foray against the sensibilities of the young practitioner in medicine Dr. Cain's statement might have gone unnoticed. However, in the March, 1960 issue of the *Journal of the South Carolina Medical Association*, there was an editorial by Dr. Guess warning us of a future pronouncement which has now appeared in the September, 1960 issue of the *Journal*. I feel that all of these things are cogent to the attitude of many physicians, as well as

myself (whom I consider a young man in medicine) and it is this "I am damn sick and tired of being criticized by so called medical savants".

Dr. Guess' recent literary escapade, *The Organization Man of Medicine*, is a querulous censure of youth in Medicine. This is an expansion of his usual theme—criticism of doctors generally for abuse of Blue Shield. Some of the disputation is of course true. Much of it is pettish. At no time is the writer introspective of his nor of his generation's failures. Thereby, he fails to advise the young doctor, from prior experience and knowledge and remains a blatant critic.

I resent the implication that young doctors are uncultured boobs. I cannot accept the premise that progress has made us so. Progress has brought many changes not all of which are good, but civilization cannot remain static—if so, it fails.

I have no doubt that it was wholesome entertainment and thoroughly enjoyable to travel leisurely through the countryside in a horse and buggy and enjoy the wonders of nature. It is terribly unfortunate that asphalt and cement have covered the dirt country roads and we travel about in automobiles and view signs advertising various products. It is terribly unfortunate that we must take the bitter with the sweet; and, whereas progress has brought us the availability at low price of cultural things which were not obtainable forty or fifty years ago, I do not think it should be condemned because it is progress. I am speaking primarily of the availability of phonograph records, books, periodicals, reproductions of works of art and so forth.

What the Doctor wishes to refer to as culture is here today no less than in his youth. In fact, it is more available. Progress has brought many things, more home owners, more automobiles, more divorces, more suicides, higher birth rates, better health, more individual wealth, a larger middle class, poor novels, a bigger national debt, etc. Not all of this is good nor desirable, but not all of it is bad, just because it is progress.

That progress has been made in medical practice should not make us disrespectful, nor should we defame the concerted interest and application of some scientific principles to what is not a science and I mean the practice of medicine. That evil of necessity follows some good is unfortunate. However, I cannot believe that the practice of medicine or what the Doctor wants to call the art of medical practice has been prostituted to pure learning.

The Doctor speaks of the need for more humanism in medicine and particularly the need of an interest in the humanities in medical education. A noble thought. I assume that his generation is much the better because of their education which presumably differs from that of today. I am unaware that all of the doctors of my generation are graduates *summa cum laude* from a Deweyite Sandpile. Such things as Latin, Greek, literature, history, philosophy, social science, romance languages and arithmetic studies

are being taught in undergraduate schools and have been studied by medical school graduates of recent generations. I hesitate to accept the premise, that past generations have cornered the market on culture, humanism, and the understanding of the individual. That the humanities in education are extremely important, I would agree with Dr. Guess. That he is worried about pre-medical curricula is a happy sign. I suggest, however, that the lack of culture depends not so much on the course of study but on the individual himself. I suggest further that Dr. Guess is looking back to glory and remembers the day when the doctor was one of the few educated men in the community. The Doctor should realize that with the great social upheaval that has come about particularly since World War I and more acutely since World War II, the college educated individual is rampant throughout the land. The Doctor doesn't only have to observe the young men in medicine but he can look about him to people in other fields of endeavor and work and he will find that many of these individuals have had excellent educations. Education itself does not imply culture and again we come back to the individual.

I object to the accusation of Dr. Guess that the young man in medicine doesn't like hard work, doesn't like to suffer discomfort and doesn't respond when called. These are specious arguments. Social change as it affects the nation affects every one individually. It is bound to have affected medical practice. I doubt that the effects are as adverse as the Doctor would have us believe. The fault in medicine seems more a selection of the individual who studies medicine and who graduates from medical school. I believe that not every one who graduates from school is necessarily deserving of the degree of Doctor of Medicine. In medical education some things are sacrificed for social, economic and political expediency.

I take umbrage at the accusation that there is no understanding on the part of young practitioners of medicine. The idea that we run people mills where we see multitudes of individuals, toss them into a common denominator and grind out diagnoses is totally erroneous. I firmly believe that in my community that the individual receives good medical care with understanding that is based on sound medical principles. I further believe that most individuals are satisfied and happy with the level of medical care that they are receiving. Most of the dissatisfaction is promoted by groups who seek gains beyond their capacities. Organized labor would be an example of this as would the organization of various aged groups in favor of the recent Forand Bill.

Dr. Guess' long association with "the Blues" affects all parts of his medical writing. The continued belaboring of the medical profession and now the young men in medicine for admitting people to hospitals for diagnostic surveys is down right disgusting. I am unaware that it is a practice to admit a patient to the hospital without telling him why he was going and what would be done to him. Dr. Guess apparently

thinks that this is more common than not. Most of my patients ask me how much things cost, and I don't think this is peculiar to my practice. I dislike the charge that we young doctors spend the patient's money recklessly and further that we take advantage of insurance companies apparently, the Blue Cross-Blue Shield in particular, in admitting patients with bogus diseases and leaving them boarding in the hospitals for long periods of time at the expense of the company involved.

To deny that there are situations in medicine that need correcting and to deny that there are individuals in medicine who should not belong to the profession and to deny that doctors as individuals or as a group are not guilty of error, would be foolish. Frankly, I am proud to be in the profession of medicine. The main stumbling block to an enlargement of the pride that each of us takes in the profession as an individual is that the scoundrels, charlatans, bums, and hangers-on, can not be dispensed with because medical organizations feel no compulsion to rid themselves of those men in the profession who abuse its privileges. These are the men who cause the profession difficulties in court cases; and in the heinous treatment—medical and economic—of individuals who have sought from them the fruits of their learning and scientific knowledge. There hardly seems to be room in medicine for jackasses. But we must realize that they exist. I doubt that they are peculiar to one particular generation.

I believe that I speak for the young men in medicine when I state that we do not feel as automatons, but hope that we function as rational human beings treating those who come for succor with compassion, albeit with sufficient scientific data to substantiate a diagnosis and direct treatment with more than the empiricism of the art of medicine alone.

Bernard E. Ferrara, M. D.
Charleston, S. C.

Comments by Dr. Guess

Youth is often hasty and noncontemplative. Anger frequently affects unfavorably thoughts and words. Words spoken in anger are often repented of the following day.

What distresses me most about the communication from the angry young man is the fact that he classifies me as an old fogey, already senile, and one who is reliving facts, impressions, and reaction of ancient age. Perhaps, he is right after all, however, the references whom I quoted or referred to in my article cannot be so classified, I believe.

Dear Dr. Waring:

Would you be kind enough to put this note in the next issue of the Journal relative to the proposed Re-registration of physicians in South Carolina on a Bi-Annual basis? It seems that despite the decision of the house of Delegates, there is considerable opposition to the re-registration plan. The State Board of Medical Examiners of South Carolina do not wish to participate in any controversy with regards to the plan. The purpose of this letter is to clarify some points in the plan which may be of concern to those who oppose it.

In the first place, the plan to re-register South Carolina physicians every other year is primarily mechanical. This work will be done by the lay secretary of the Board with what help he might need to employ. Secondly, re-registration will in no wise concern itself with who should be registered and who should not be, except for the following categories: those who are deceased will be deleted; those who no longer practice may re-register or not re-register, as they please; those who have had their licenses revoked by the State Board of Medical Examiners and those who have had their licenses revoked by the Courts of South Carolina or elsewhere.

A complete list of all licensed physicians would be published every other year on the odd years. Supplements would be sent out which would include all new registrants, re-registrants, and a list of the deceased. Such a reference would find much use in our offices, and so far as I can see should embarrass no one.

On due notice all registrants would have an opportunity to register and if they failed to register within a certain period (30 days) they would have their license suspended. Should they at any time desire to be re-registered, they could pay up what the mechanics of the registration cost and have their license reinstated without prejudice. This device will fill many needs, will cost very little, and might save a great deal of time.

In conclusion, should the matter be worthwhile re-considering by the House of Delegates, Council, *et al* I see no reason why anyone should be too much upset. The society has gone along happily and peacefully for many years without re-registration, but like new forms of taxes, integration, and many other things, it appears that we will be keeping step if we go along with the rest of the states in a matter which does not involve any moral turpitude.

Sincerely yours,
George R. Wilkinson, M. D.

MINUTES OF COUNCIL MEETING

Columbia, S. C. — October 26, 1960

A special meeting of Council was held at the Columbia Hotel on October 26, 1960. The meeting was called to order at 3 P. M. by the Chairman, Dr. J. H. Gressette. Present at the meeting were Drs. J. P. Cain, Brewer, Perry, Burnside, Weston, Jr., Waring, Stokes, Evatt, Scurry, Eaddy, Johnson, Booker, Wilson and Mr. M. L. Meadors.

The minutes of the meetings of May 17, 18, 19, 1960 held at Myrtle Beach were read and approved.

Dr. J. P. Cain spoke on the necessity for filling the position for Medical Director of Civilian Defense and the question of whether a full time physician should be appointed for this office, to organize and assist in the setting up of a program of civilian defense in the various counties of the state. Mr. Charles Culbertson, Director of Civilian Defense, spoke on the needs of filling this position and brought up the question as to whether a physician or a layman, either trained as an executive, or perhaps a retired medical administrative officer, could be obtained. After considerable discussion it was moved that the authority for making the decision as to whether a physician or a layman qualified in administration be chosen as Medical Director of Civilian Defense be referred to the ad hoc committee for this purpose, (Dr. Weston, Jr. Chairman, Drs. Cain, Gressette and Wyatt) with power to act. This motion was passed. It was further moved and carried that Council approve a request to the budget and control board for this purpose, and that the Secretary be directed to write a letter to this effect.

Dr. J. P. Cain then spoke on the question of bi-annual registration of physicians, which had been approved in principle by the House of Delegates in 1959 and reaffirmed by action of the House in Myrtle Beach in May 1960. He spoke of the opposition of the Edisto Medical Society to this proposal, and read a letter outlining his position as President of the Association. Dr. Cain then presented a question and answer statement that he had prepared on this question. Dr. Harold Jervey appeared before Council and presented the views of the State Board of Medical Examiners. After some discussion it was moved that the President of the Association be advised to defer action in this matter until the next meeting of the House of Delegates. This motion was carried with Dr. Weston, Jr., Dr. G. D. Johnson and Dr. Burnside dissenting. The President announced that he intended to publicize the matter to the membership of the Association, so that everyone would be in a position to make an intelligent decision on this matter at the next meeting of the House of Delegates.

Dr. Frank Owens then presented a proposed fee schedule for Workman's Compensation Cases in South Carolina which he stated had been approved by his committee, meeting in conjunction with representatives of the Chamber of Commerce. The Council gave their approval to the proposed schedule.

Dr. John Brewer noted that the total invested funds of the Association amounted to approximately \$42,000 with an annual income of approximately \$1600.

Dr. O. B. Mayer, a member of the Trustees of the Benevolent Fund, then appeared before Council and gave a report on activities of this Board. He suggested that further funds might be obtained by interesting the various Women's Auxiliary Organizations to contribute to the Fund, and further suggested that the bill head for annual dues for the Association include a voluntary contribution to the Fund. After considerable discussion it was recommended that \$800 be appropriated for the balance of the year 1960, in addition to the \$900 previously authorized, to be paid out of the General Fund of the Association. A motion to this effect was carried.

The Secretary reported on the matter of defraying the expenses of a student representative to the Annual Meeting of the Student American Medical Association, and the Treasurer was directed to pay up to \$150 for this purpose, the remainder of expenses to be defrayed by the Charleston County Medical Society.

The Secretary reported on a letter received from Mr. S. J. Ulmer regarding diets for nursing homes in the state. This matter has been considered by the State Board of Health and was received as information. A letter from the American Diabetes Association was read regarding the participation of the State Association in the Diabetes Detection Drive during November 1960 was likewise received as information.

A letter from the S. C. Society of Ophthalmology and Otolaryngology regarding an increase in fees for tonsillectomies was received as information.

Dr. William Weston, Jr. spoke on the question of the S. C. Medical Association proposing Dr. Julian Price as President-Elect of the American Medical Association. It was directed that the President of the Association, the Chairman of Council, and the Delegates to the AMA should write to all members of the House of Delegates of the American Medical Association proposing Dr. Price for this office.

Dr. J. I. Waring spoke on the needs of *The Journal* and commented on suggestions for approving its appearance. The Editor was given authority to do this, as well as to edit the minutes of the meetings of the House of Delegates so that they should not be altogether stenographic reports, but should include actions taken by the House. Dr. Waring further spoke on the Public Relations programs and expressed the opinion that perhaps there should be fewer television programs. He suggested a speakers bureau, to be available to furnish speakers on various matters of medical interest, and was given authority to proceed along this line. Dr. Waring also announced that he had been working on the preparation of a folio to contain information of interest for new members of the Association and he was given authority to continue to put this into effect.

Dr. J. P. Cain then spoke on the program of the S. C. Committee on Children and Youth. Certain of

the proposals for action during 1960-1970 were cited; (a) To abolish laws which permit deeding and indenture of children; (b) To enact state labor legislation to coincide with federal child labor laws; (c) To require employment of age certificates for young workers under 18. These considerations were approved and the Legislative Committee was instructed to study these proposals and to take appropriate action regarding legislative proposals when introduced.

Dr. Cain then presented a letter from a representative of the Inter-Association Committee on Nursing Education; this was received as information and as President he was instructed to find out details of this committee, of which Council was unaware. Dr. Cain then announced that the Program for the meeting of the State Association in Charleston, April 1961, had been largely formulated, and that in addition to some local speakers the faculty of the University of North Carolina Medical School in Chapel Hill had been invited to put on the Scientific Program, which invitation had been accepted.

Dr. Cain further announced that the Alumni Association would sponsor a "President's Breakfast" on Thursday morning of the meeting, at which time the report of the Memorial Committee and the President's Address would be heard.

Mr. M. L. Meadors announced that arrangements had been made for the Annual Meeting to be held April 25-27, 1961 at the Francis Marion Hotel in Charleston. He further suggested that "Today's Health" be sent to U. S. Senators and Congressmen, to the Governor, and to the members of the State Legislature as had been done during the past year. A motion to approve this proposal was passed.

Mr. Meadors then presented a proposed retirement plan for certain members of the permanent staff of the Association, which had been worked up in conjunction with representatives of the Penn Mutual Insurance Co. After a motion to accept this as information was lost, it was moved and seconded that the matter be referred to the Committee on Insurance, with instructions to report back to Council.

Dr. J. I. Waring suggested that as part of the Program for the Annual Meeting, that one feature of the entertainment be a production by the Footlight Players of Charleston at the Dock Street Theater. It was moved and carried that the Program Committee be instructed to buy out the house for one night of the meeting, with tickets to be sold back to members of the Association who desired to attend this performance.

Dr. Eaddy noted that the fee schedule for the Department of Public Welfare had not been brought up to date for more than 20 years and moved that the President of the Association appoint a committee to investigate this fee schedule, as well as the schedule affecting all other agencies of the State for which medical fees were paid. This motion was carried.

Dr. Booker suggested that perhaps the membership of the Association for Blue Cross be organized on a

state wide basis rather than as individual county groups; a motion to refer this to the Insurance Committee was carried, with instructions to report on their findings back to Council.

The budget for the calendar year 1961 was then considered and the following budget was adopted.

<i>Secretary</i>			
Office help	\$	900.00	
Office expense		600.00	
Travel		500.00	
Total			\$ 2,000.00

<i>Treasurer</i>	\$	100.00	\$ 100.00
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<i>Journal</i>			
Office expense	\$	3,000.00	
Editor's salary		3,000.00	
Adv. Mgr. Salary		1,200.00	
Printing		25,000.00	
Total			\$32,200.00

<i>Executive Secretary</i>			
Salary	\$	10,000.00	
Office help		7,500.00	
Travel		1,500.00	
Rent		1,200.00	
News Letter		800.00	
Office supplies		1,500.00	
Tel. & Tel.	\$	1,500.00	
Conf. and P. R.		750.00	
Insurance		600.00	
Postage		1,000.00	
Total			\$26,350.00

<i>Delegates to A.M.A.</i>			
Travel	\$	1,800.00	\$ 1,800.00

<i>President's Expense</i>	\$	1,200.00	\$ 1,200.00
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<i>General Expenses</i>			
Woman's Auxiliary	\$	1,500.00	
President's Gift		200.00	
Historical Committee		500.00	
Infant and Child Health		200.00	
Maternal Welfare		200.00	
Contingent Fund		1,500.00	
Civil Defense		500.00	
Auxiliary Bulletin		1,000.00	
Medico-Legal		1,000.00	
Directories		2,000.00	
P. R. Committee		2,500.00	
Taxes		750.00	
Hospitality by State at AMA		500.00	
Misc. Committee Expense		500.00	
Benevolent Fund		1,000.00	
Total			\$13,850.00
			\$77,500.00

During the discussion of the budget the President and the Executive Secretary were authorized to associate themselves with various other Southeastern

States and see if a "Hospitality Room" could be established as a regular feature at meetings of the American Medical Association, for entertainment and relaxation for members of the South Carolina Medical Association attending these meetings.

There was no further business and the meeting adjourned at 8:05 P. M.

Respectfully submitted,
Robert Wilson, M. D.
Secretary

News

FROM THE "ALUMNI BULLETIN," UNIVERSITY OF TEXAS SCHOOL OF MEDICINE, OCTOBER 1960.

"On 30th June DR. KENNETH M. LYNCH retired as president and dean of the Medical College of South Carolina. Dr. Lynch will continue to be active in academic medicine. He was appointed Chancellor for the Medical College, and will remain on the staff of Charleston hospitals affiliated with the College. Dr. Lynch also continues as consultant in pathology and to pursue his experimental research.

"Born in Hamilton County, Texas, Kenneth Lynch grew up on a ranch. He was graduated in 1910. Following internship and training at the University of Pennsylvania Dr. Lynch was appointed professor of pathology at the Medical College in 1913. He was vice-dean from 1935-43, dean from 1943-49, and became president in 1949. During Dr. Lynch's administration growth and expansion of the Medical College was unprecedented. All departments and branches attained a productive wealth which has placed the South's oldest medical school foremost in the ranks of medical education.

"Dr. Lynch has been awarded and has received many honors; he is a member of numerous national and regional societies and has served on research grant boards in New York and Washington. His original contributions number 101 and he is author/collaborator of several books. To such a distinguished Texan's career, in the summing up, can be added only the words of Dr. Jack Norris, alumnus of the Medical College of South Carolina: 'Doctor Lynch has built here that our citizens may have good health and a better life, and both more abundantly. That's all there is; there's nothing more to say.'"

DR. PRYOR TO TAKE OFFICE

Dr. William W. Pryor was recently elected president of the Greenville County Heart Council.

Outgoing president Dr. John Muller said, "It is most important that we have a strong and effective heart council, because diseases of the heart and blood vessels are the most serious threat to the health of the citizens of Greenville County."

Dr. Pryor and his associate, Dr. Arthur G. Meakin, specialize in internal medicine and cardiology.

CLINICAL GROUP

Dr. George Rosenberg of Abbeville was elected president of the Piedmont Post-Graduate Clinical Assembly at the 25th annual meeting at Clemson College.

Dr. Rosenberg succeeds Dr. John T. Davis of Wall-halla.

Dr. William Lummus of Anderson was elected executive vice president. Other officers are Dr. Frank Espey of Greenville and Dr. Lewis Caechioli of Hartwell, Ga., vice presidents; Dr. William H. Hunter of Clemson, re-elected registrar, and Dr. Ned Camp of Anderson, re-elected secretary-treasurer.

Highlight of the closing day was an address by Dr. John T. Cuttino, dean of the Medical College of South Carolina.

DeWitt Shelton, M. D. announces the opening of his office for the practice of Psychiatry at 124 Bull Street, Charleston.

STATE'S SURGEONS ELECT DR. LYNCH, JR. PRESIDENT

Dr. Kenneth Lynch, Jr., professor of urology at the Medical College of South Carolina, has been named president of the South Carolina Chapter, American College of Surgeons.

Dr. William Canteley of Columbia was named vice president and Dr. Randy Bradham of Charleston was elected secretary-treasurer.

Named to the council were: Dr. George McCutcheon of Columbia, Dr. Fred Kredel of Charleston, Dr. Roderick McDonald of Rock Hill, Dr. William Brockington of Greenwood and Dr. J. Robert Thomason of Greenville, the group's retiring president.



MEDICAL COLLEGE RESEARCH-CLINIC BUILDING

Preliminary plans for a seven story, \$1,160,000 medical research-clinic building were recently approved by the Board of Trustees of the Medical College of South Carolina. College officials stated that the first floor is to serve as an expansion of the out-patient clinic examining areas while the upper six floors are to be completely utilized for basic research projects. Funds were provided through the State Budget and Control Board from tuition revenue bonds with equal matching funds from the Hill-Burton Act and the Health Research Facilities Branch of the Public Health Service. Drawings and specifications are being prepared by Baker and Gill, Architects, of Florence, assisted by Rigby and Associates, engineering consultants. The site on Mill St. permits communication through passage ways at 3 levels with the Basic Science buildings in the area near the overhead bridge at the Hospital. Exterior styling is traditional and in conformity with other buildings of the Medical Center. About 75 investigative studies are now under way at the College and are supported by grants from outside sources amounting to about a million dollars

annually. Completion of this building will concentrate these activities in better working proximity and is expected to strengthen their competitive position in securing further financial support. The present College buildings were intended almost entirely for teaching, hospital service and dormitory space.

Interior functional plans of the research-clinic building were designed after faculty representatives inspected several other similar projects in the South-eastern states. For the most part, simple uniform room space is provided with emphasis on adaptability for future changes.

In addition to the regular staff and full-time technicians, several training categories participate in research projects at the College. These projects are the primary activity of graduate students working toward M. S. and Ph. D. degrees in medical sciences. Additional collaboration develops through medical students working in summers, and interns and residents working on special assignments. The educational value of research experience is currently recognized in the programs of most medical schools and in the intern and residency programs of large hospitals. Some of the current grants at the College are specifically for research training in these categories.

DR. ZEIGLER ELECTED

Dr. Rowland F. Zeigler of Florence was installed as president of the South Carolina Obstetrical and Gynecological Society, succeeding Dr. David F. Watson of Greenville at meetings held in Greenville October 21-24.

Dr. James M. Wilson of Charleston was named president-elect to take office next year. Dr. John Richard Sosnowski was installed as secretary and treasurer.

The 14th annual meeting of the state society was concluded following rounds at Greenville General Hospital and clinic study.

MEDICAL COLLEGE SYMPOSIUM

Forty-five physicians from Orangeburg and the surrounding area of fifty miles radius attended the first circuit course of the proposed new series at Orangeburg on October 26th held under the auspices of the Continuation Education Committee of the Medical College in collaboration with the Edisto Medical Society. The subject of the Symposium was "Strokes" and participants were Drs. Vince Moseley, O. Rhett Talbert, Harry Mims, with Dr. Dale Groom as Moderator.

FACIAL SURGERY PRACTICE OPENS

Dr. Clarence W. Workman, a native of Spartanburg County, has opened the first maxillo-facial plastic and reconstructive surgery practice in Greenville.

He has just completed training in the practice of reconstruction after facial injuries. Dr. Workman has a medical and dental degree, DDS and MD.

CATAWBA LAKE IS RE-NAMED FOR DR. WYLIE

It's now Wylie Lake and Wylie Hydroelectric Station on the Catawba River near Rock Hill.

The renaming honored the memory of the late Dr. Walker Gill Wylie, physician and co-founder of the Duke Power Co.

They were known as Catawba Lake and Duke Power Company Station.

Governor Hollings praised Wylie as "the father of modern electricity in South Carolina."

Wylie, a native of Chester, interested the late tobacco millionaire B. N. Duke in investing in the hydro plant on the Catawba River in 1904.

DR. HINSON IS SELECTED

Dr. Angus Hinson of Rock Hill has been selected to represent the field of general surgery on the Medical Advisory Committee of the State Vocational Rehabilitation Department.

He was selected and approved by the South Carolina State Agency of Vocational Rehabilitation. The appointment will terminate December 31, 1962.

The South Carolina Academy of General Practice named new officers recently at the annual meeting held at Memorial Auditorium. They are Dr. Jim Blanton of Chesnee, treasurer; Dr. Swift Black of Dillon, president-elect; Dr. Martin M. Teague of Laurens, president; Dr. Horace Whitworth of Greenville, vice president, and Dr. Bill Bannon of Simpsonville, secretary.

THE MONTH IN WASHINGTON

Election of Sen. John F. Kennedy as President made it probable that the issue of providing health care for the aged under Social Security again will be raised in Congress next year.

Kennedy will go into the White House pledged "to the immediate enactment of a program of medical care for the aged through Social Security." His intentions present a serious challenge to the nation's physicians who have vigorously opposed use of the Social Security system to provide health care for the aged.

Kennedy's program would provide what he described as "a life policy of paid-up medical insurance" for older persons. "It would provide them hospital benefits, nursing home benefits and X-rays and laboratory tests on an out-patient basis," he said in his campaign for the Presidency.

He said the Kerr-Mills legislation enacted into law last summer is inadequate. The medical profession

supports this federal-state program to provide health care for needy and near-needy aged persons. In approving the Kerr-Mills program, Congress rejected the Social Security approach espoused by Kennedy and union labor leaders.

Kennedy's medical program also included: federal grants for construction, expansion and modernization of medical, dental and public health schools; federal loans and scholarships for medical students; federal grants for renovating older hospitals; increased federal financial support for medical research, including basic research, and expansion of federal programs for rehabilitation of handicapped or disabled persons.

A. M. A. Washington Office

DR. F. C. McLANE HEADS SOCIETY

Dr. F. C. McLane has been reelected president of the Greenwood County Medical Society.

Elected to serve with Dr. McLane are Dr. R. M. Christian, vice president, and Dr. Guy Calvert, secretary-treasurer.

A program on "Disability Under Social Security" was presented by Ben Marrett of Columbia and Miss Martha Pressley of Greenwood.

PEE DEE MEDICAL ASSOCIATION

At a recent meeting held in Florence, the following officers were elected: Dr. Roy Howell, president for 1961-62; Dr. George Smith, secretary; Dr. Douglas Jennings, Vice-president from Marlboro; Dr. Jim Warren, Vice-president from Dillon; Dr. Randy Elvington, Vice-president from Marion County. Mr. M. L. Meadors has agreed to be Public Relations and Publicity Chairman, a new position.

DOCTORS NEEDED

The Defense Department will ask the drafting of up to 500 doctors during the next fiscal year, the Army Navy Air Force Journal predicted today. The doctor draft has not been used since February, 1957, the unofficial but authoritative service publication said and during this time not enough interns and resident physicians have been volunteering to meet requirements. A decision of the exact size of the doctor draft quota will be made after March.

DR. GEORGE G. DURST ELECTED CLEMSON ALUMNI PRESIDENT

Dr. George G. Durst, a 1930 Clemson College graduate now practicing medicine at Sullivan's Island, is the new president-elect of the Clemson Alumni Association.

He was elected by a mail ballot of the association's members and will serve as national president of the Clemson Alumni Association for the calendar year 1962.

The new president-elect of the Clemson Alumni Association is a general practitioner and treats patients for every ailment ranging from an ingrown toenail to emotional disturbances.

His practice is spread throughout Sullivan's Island

and nearby Isle of Palms and Mount Pleasant, and ranges as far north as McClellanville.

He's a busy man. Aside from the burden of a heavy medical practice, he takes an active part in community, civic and political life.

His practice on Sullivan's Island began in 1948, following his retirement from the U. S. Army with the rank of colonel. Promoted to full Colonel at 35, Dr. Durst is believed to have been one of the youngest men to attain that rank in the Army Medical Corps in World War II.

He holds a Bronze Star medal for "his alertness and constant insistence on proper medical screening, thus making sure that reinforcements passing through his command were in top physical shape prior to assignment to combat units."

As an Army doctor, Col. Durst played an important part in the furnishing of reinforcements during the Normandy invasion and subsequent fighting in France and Germany.

He attended the University of Chicago Graduate School and the Medical College of South Carolina, graduating with honors. He has done postgraduate work at Cincinnati General Hospital, and entered the service as a specialist in internal medicine.

Girard C. Rippy, Jr., M. D. has announced the opening of his office for the practice of Obstetrics and Gynecology at 805 North Fant Street, Anderson.

ACCEPTS POST IN INDO-CHINA

Dr. Bob O. Lipe of Chester has accepted a position in Public Health with the U. S. Mission for International Cooperative Administration with headquarters at Phnom Penh, Cambodia, French Indo China.

Dr. Lipe had practiced as industrial physician to the Springs Cotton Mills since 1957.

Two more young physicians plan to begin practice in Anderson soon. They are Dr. John D. Martin, Jr., of Liberty, and Dr. Robert Smith Clark of Due West. Both are graduates of the Medical College of South Carolina.

DR. MCCALL JOINS VA HOSPITAL

Dr. Robert E. McCall, thoracic surgeon formerly of the VA Hospital staff at Dublin, Ga., has recently joined the staff of the Columbia VA Hospital.

Dr. McCall received his M. D. degree from Jefferson Medical College, Philadelphia, Pa., in 1936, and has completed approximately seven years' graduate study in general and thoracic surgery. He was certified by the American Board of Surgery in 1952.

He served for 4½ years in the U. S. Army and was discharged as a Major.

Dr. McCall first joined the VA in 1956 at the Augusta, Ga. Hospital. He also served one year on the surgical staff at the VA Center, Wadsworth, Kansas. Prior to government service he was engaged in

private practice in general and thoracic surgery for approximately four years.

THE AMERICAN COLLEGE OF SURGEONS

The following were inducted as new Fellows of the American College of Surgeons at San Francisco on October 14, 1960:

Dr. Thomas F. Stanfield, Anderson; Dr. William T. Lineberry, Jr., Cmdr., USN, Beaufort; Drs. Daniel W. Boone, Jr., Capt., USN, Henry R. Ennis, Capt., USN and Carter P. Maguire, Charleston; Dr. Stanley C. Baker, Jr., Greenwood; Dr. Richard C. Horger, Orangeburg; and Dr. Belton J. Workman, Jr., Woodruff.

Dr. Julian P. Price, Florence pediatrician and chairman of the board of trustees of the American Medical Association, was the guest speaker at the October "Father's Night" meeting of the Kingstree Parent-Teachers Association.

Dr. Price was born to missionary parents in Sinciang, China. He is a graduate of Davidson College and Johns Hopkins University School of Medicine. He was secretary-treasurer of the S. C. Medical Association for ten years, and was editor of the Journal of the S. C. Medical Association. Dr. Price has also been interested in education and has served on the Florence school board.

Dr. Griggs C. Dickson, one of Hartsville's new pediatricians, recently spoke to a group on the Child's Health in Relation to his School Work, at Hartsville.

Dr. Dickson completed his residency at North Carolina Memorial Hospital. He has also served with the Navy Medical Corps.

Dr. Dickson and Dr. J. C. Parke plan to build a modern clinic for children some time in the near future in Hartsville.

FOUR DOCTORS JOIN SOCIETY

Four physicians have joined the Greenville County Medical Society recently.

The doctors are Dr. George O. Bailey who is associated with Dr. William S. Freeman, 12 Greenacre Road in practice of general medicine.

Dr. Halliburton C. Batson, associated with Dr. W. H. Powe, Jr., 202 N. Brown St., also is in the practice of general medicine. Both Dr. Bailey and Dr. Batson attended Furman University and Medical College of South Carolina.

Dr. Calvin T. Smith is in the practice of urology with Drs. Nachman and Armstrong, 413 Vardry St. He attended Mars Hill College and Bowman Gray School of Medicine.

Dr. Claude B. White has an office at 700 Arlington Ave. for the practice of dermatology. He was recently stationed at Donaldson AFB, serving as base surgeon with the rank of colonel.



Dr. W. Atmar Smith, Charleston, 1960 Christmas Seal Campaign Chairman recruits the assistance of his grandchildren in the fight against tuberculosis.

"Tuberculosis is as old as civilization itself and it might become older if the civilized world does not soon become more civilized."

"The decline in the death-rate in the past half-century from approximately 200 to less than 10 per hundred thousand since the organization of tuberculosis associations, may be regarded as an outstanding public health accomplishment. The factors concerned in bringing this about were both biological and economic but the acceleration of the downward mortality trend in recent years is directly due to aggressive human effort."

"Tuberculosis is a complex disease; its manifestations are many and varied. It frequently simulates other pathological entities; its chronicity can plague its victim throughout a long lifetime."

"Our knowledge concerning the exciting cause, the pathology and treatment of tuberculosis is colossal but our ignorance concerning the factors of resistance, immunity and allergy is abysmal."

"The tuberculin test is an instrument of value in epidemiology and it has a certain place in differential diagnosis."

"The discovery, development and perfection of the X-ray has been the greatest of all contributions to the diagnosis of chest diseases, but its use on a national scale for the purpose of detecting tuberculosis has not proved as effective in the eradication of this disease as its sponsors believed."

"The evolution of the tuberculosis sanatorium from the "shack" to the modern hospital dramatizes the evolution of the therapy of tuberculosis."

"The properly conducted community Tuberculosis Sanatorium fulfills a three-fold function—isolational, curative and educational."

"An alert, adequately trained medical profession is the vanguard in the attack on the ramparts of tuberculosis."

"Encouraging inroads against tuberculosis are being made but many vital problems bearing directly upon its prevention remain unsolved. Their solution de-

mands unrelenting scientific research, wise medical leadership supported by an enlightened and generous public."

—William Atmar Smith, M. D.

DR. W. A. SMITH HONORARY HEAD OF SEAL CAMPAIGN

Dr. W. Atmar Smith, chief consultant at Pinchaven Tuberculosis Hospital will be 1960 honorary Christmas Seal chairman for South Carolina, Dr. Edward F. Parker, president of the S. C. Tuberculosis Association has announced.

A graduate of The Citadel and the Medical College of S. C., Dr. Smith was awarded an honorary LLD degree from The Citadel in 1956.

Dr. Smith is a trustee of the S. C. Sanatorium at State Park, vice-president of the American Trudeau Society, medical section of the state association, member of the American Board of Internal Medicine, and president of the Society for the Relief of the Families of Deceased and Disabled Indigent Members of the Medical Profession of the State of S. C.

Formerly, he has been president of the S. C. Medical Association, president of the Medical Society of S. C., president of the S. C. Tuberculosis Conference, consultant in chest disease of the U. S. Veterans Administration, Medical Director of Pinchaven Tuberculosis Hospital, and professor emeritus of clinical medicine at the Medical College of S. C.

DOCTORS BUILD CENTER

Construction of a \$75,000 medical center is under way in Walhalla on the corner of S. Broad and Church Sts., just across from the County Health Center. Owners of the property are Dr. J. P. Booker and Dr. Sam Moyle, local physicians.

In the structure will be accommodations for four doctors and an apothecary shop.

Also included will be complete laboratory and x-ray facilities, emergency operating room, and physiotherapy department.

STATE ACCIDENT PREVENTION CONFERENCE

The annual South Carolina State Accident Prevention Conference was held Wednesday and Thursday, November 9-10, at Hotel Wade Hampton and Hotel Columbia.

A program, "Home Poisoning," was presented with the leading authorities in the state present.

Dr. Margaret Jenkins, director of the Poison Control Center at the Medical College Hospital at Charleston and member of the State Medical Association accident prevention committee, headed up the program.

Dr. Henry W. Moore, director of the Poison Control Center at Columbia Hospital, and chairman of the South Carolina Chapter of the American Academy of Pediatrics accident prevention committee, gave a look into the Hazardous Substance Labeling legislation on Federal and State levels. There was also a



TEN PAST PRESIDENTS

The ten doctors above are all past presidents of the South Carolina Medical Association—but they are not identified. Any information about any of them will be greatly valued by The Editor.

film, an exhibit on sample safety medicine bottles and caps and two new home safety exhibits.

Presiding at the Home Safety Section 2:30 Wednesday afternoon at Hotel Wade Hampton was Earl W. Griffith, director Home Safety, S. C. State Board of Health.

Two other section meetings were also planned, including a section on First Aid, Boating and Water Safety, and another on State, County, School and Municipal safety activities.

HELLER HONORED

Dr. John Roderick Heller, president of the Sloan-Kettering Institute Cancer Center in New York City, was honored by his home county on November 22. Mr. E. R. Alexander, president of the South Carolina Division, American Cancer Society announced the celebration of "John Rod Heller Day," sponsored by the Seneca Chamber of Commerce to pay tribute to the native of Fair Play, S. C. who has been honored in numerous ways for his contributions to the cancer control cause as well as for his service to mankind.

MEDICAL HISTORY OF WAR OFFERED

Many of the medical lessons learned during World War I had to be relearned under fire during World War II because of paucity of distribution of the World War I medical history.

Lieutenant General Leonard D. Heaton, The Army Surgeon General in an endeavor to prevent this costly relearning process, in the unhappy event of another war, has directed the preparation, publication, and distribution of the "History of the Medical Department, United States Army, in World War II." Gen-

eral Heaton is particularly anxious that information of the existence and availability of this History be circulated widely among the profession, both military and civilian.

Of the 48 volumes programmed for the series, 15 have been published and can be purchased at modest cost from The Superintendent of Documents, Government Printing Office, Washington 25, D. C. The set of 15 volumes may be purchased for \$66.50 or individual volumes can be obtained at remarkably low prices. Commanding officers of medical units may requisition copies for their Medical Units libraries by submitting DA Form 17 directly to The Historical Unit, U. S. Army Medical Service, Washington 12, D. C., ATTN: Promotion Branch.

Volumes now available are:

"General Surgery"—Edited by Michael E. DeBakey, M. D.

"Neurosurgery," Volume (Head Injuries)—Edited by R. Glen Spurling, M. D. and Barnes Woodhall, M. D.

"Neurosurgery," Volume II (Spinal Cord and Peripheral Nerve Injuries)—Edited by R. Glen Spurling, M. D. and Barnes Woodhall, M. D.

"Hand Surgery"—Edited by Sterling Bunnell, M. D.

"Ophthalmology and Otolaryngology"—Edited by M. Elliott Randolph, M. D. and Norton Canfield, M. D.

"Orthopedic Surgery, European Theater of Operations"—Edited by Mather Cleveland, M. D.

"Orthopedic Surgery, Mediterranean Theater of Operations"—By Oscar P. Hampton, M. D.

"Physiologic Effects of Wounds"—Edited by Fred W. Rankin, M. D. and Michael E. DeBakey, M. D.

"Vascular Surgery"—Edited by Daniel C. Elkin, M. D. and Michael E. DeBakey, M. D.
"Cold Injury, Ground Type"—By Tom F. Whayne and Michael E. DeBakey, M. D.
"Dental Service"—George F. Jeffcott, D. M. D.
"Environmental Hygiene"—By James Stevens Simmons, M. D. and others

"Personal Health Measures and Immunization"—By John E. Gordon, M. D., Tom F. Whayne, M. D. and others
"Communicable Diseases," Volume IV—By John E. Gordon, M. D., Joseph Stokes, M. D. and others
"Hospitalization and Evacuation, Zone of Interior"—By Clarence McKittrick Smith

Announcements

PAPERS FOR 1961 MEETING

All members of the South Carolina Medical Association who would like to present papers of no longer than fifteen minutes at the Annual Meeting in April, 1961, should submit a summary or abstract of such a paper to Dr. Cathcart Smith, Conway, S. C., the Program Chairman, by January 15.

NUTRITION INSTITUTE

An Institute on matters of nutrition will be held at the Medical College of South Carolina in the Baruch Auditorium on January 24 and 25. It will run the whole day of January 24 and for half a day on the second day of the meeting. This Institute is sponsored by the State Nutrition Committee and by the Medical College of S. C.

The topic of the discussions will be "Nutritional Advances as Related to Health Problems." Three out of state speakers eminent in the field of nutrition have been invited to participate and will be supplemented by in-state presentations.

A feature of the meeting will be a tour of the research facilities of the Medical College.

This meeting is open to all interested persons.

The Northeast Florida Heart Association will hold its Annual Cardiovascular Seminar in the Prudential Auditorium, Jacksonville, January 26, 27, and 28, 1961.

The participating physicians are the following: Dr. William Dock, Dr. Lewis Dexter, Dr. Milton Rosenbaum, and Dr. Richard Ebert.

For further information write:

Dr. Daniel R. Usdin
1628 San Marco Boulevard
Jacksonville, Florida

SYMPOSIUM ON NEPHROLITHIASIS

A one day Symposium covering the metabolic and clinical aspects of nephrolithiasis will be held at Charleston at the Francis Marion Hotel on February 23, 1961 under the auspices of the Medical College and the Alumni Association and with the support of Lederle Laboratories.

There will be a luncheon to which the wives of

physicians are invited, and a social hour for all in attendance at the conclusion of the program.

Competitive examinations for appointment in the Regular Corps of the U. S. Public Health Service will be held throughout the country January 31 through February 2 or 3, 1961, Surgeon General Leroy E. Burney announced today. The examinations cover nine professional health, medical and scientific categories. Applications must be made before December 2, 1960.

Application forms and further information may be obtained by writing to the Surgeon General, U. S. Public Health Service, Washington 25, D. C., Attention: Division of Personnel.

Duke University offers a series of Resident Lectures in Ophthalmology from 7:30 to 8:30 p. m. on the following dates: January 3, 10, 17, 24, 31; February 6, 13, 20, 27.

For detailed information write:

Dr. J. Lawton Smith
Department of Surgery
Division of Ophthalmology

All ethical physicians are invited.

EIGHTEENTH ANNUAL WATTS HOSPITAL SYMPOSIUM

Durham, N. C. February 3 and 4, 1961

Complimentary barbecue dinner will be served early for those desiring to attend the Carolina-Duke basketball game Saturday night. A limited number of reserved seats at \$2.50 are available. Please inform Dr. G. W. Crane, 1200 Broad St., Durham, N. C., as to number of tickets desired immediately.

CONFERENCE ON THE AGED

The White House Conference on the Problems of the Aged will be held in Washington Jan. 9-12, 1961. Mrs. Martha Thomas Fitzgerald of Columbia, is chairman of the State Legislative Committee on aging.

A list of the 24 delegates includes only two physicians, Dr. John Buse of the Medical College and Dr. G. E. McDaniel of the State Board of Health.

(Continued from page 528)

syndrome in addition to the original pathology") and, finally, the never-failing floodtides of professional jargon, a sort of mental shorthand that defeats the very purpose it was invented to fulfill. "I operated this patient under general anesthesia" appears in at least six of every ten manuscripts received by the editor of any surgical journal. According to Webster, the verb "operate," used without "upon," whether applied to a patient, a machine or a corporation, means to conduct, to carry on, to cause to run. It follows, therefore, that only God can operate a man. Furthermore, if the surgeon actually did operate under general anesthesia, as his diction and punctuation suggest, Heaven help the patient! One surgeon, according to a recently published handbook (*The Physician-Writer's Book*, by Richard M. Hewitt) claims to have gone still farther; he performed the operation in the knee-chest position. This is what the New Yorker would call the neatest trick of the week.

One might reasonably suppose—there is plenty of evidence—that straight-forwardness and simplicity in

medical writing had been officially banned. Who, then, imposed the ban? Not the editors, certainly, who labor daily against these assaults on the language. Not the reader, just as certainly; faced with those massed batteries of polysyllables, he confines himself more and more to the reading of abstracts. Even here he is in danger for the abstractor too often is bitten by that coldest of monsters, the meaningless jargon which the style of the moment apparently accepts as a scientific ideal.

One of the best pieces of prose in English is Hil-
aire Belloc's *The Mowing of a Field*. If the young doctor were to keep this at his side, he would catch the rhythm, flow and beauty of words and would find it a great help in making his medical writing sparkle with meaning and clarity.

If such a ban exists, then, it is self-imposed by the authors, and only they can remove it. Is it going too far to suggest that even they might find its removal a relief?

(Reprinted by permission from the Journal of the International College of Surgeons 27:779-781, June, 1957.)

Book Reviews

Dover Publications, Inc., 180 Varick Street, New York 14, New York has made available through inexpensive but attractively done editions, a number of books which are out of print or very hard to come by. In the medical field, this company has brought to us three moderately priced reprints of books which should be valuable to anyone interested in the history and background of medicine.

The first, *A SOURCE BOOK IN MEDICAL HISTORY*, compiled by Logan Clendenning (\$2.75) offers us a great deal of material which has been of the greatest importance in the progress of medicine. There are 124 papers accompanied with critical and biographical notes by the editor ranging through the classics of medicine with occasional detours into the writings of medical interest which were done by such people as Thackeray, Dickens, and John Brown.

CLASSICS OF MEDICINE AND SURGERY (\$2.25) collected by C. N. B. Camac, include twelve papers which have been real revolutionary contributions to the course of medicine. They are unabridged, and they include such outstanding figures and authors as Lister, Harvey, Laennec, Jenner, and others of similar stature.

EXPERIMENTS AND OBSERVATIONS ON THE GASTRIC JUICE AND THE PHYSIOLOGY OF DIGESTION, by William Beaumont (\$1.50), includes a sketch of the life of Beaumont by Sir Wil-

liam Osler, with comment on Beaumont's work, and is a facsimile reprint of Beaumont's original contribution.

All of these books are excellent for the bedside table and will certainly afford worthwhile browsing to any physician.

JIW

CARDIAC EMERGENCIES. Harold D. Levine, M. D. 381 pages. Landsberger Medical Books, Inc., New York 1960. \$12.00.

The most exhaustive and probably the best of current volumes on the subject, it is not of a size to be carried around in the pocket, or even the Boston bag, but still can be easily read and understood by the physician who must meet these emergencies in his daily practice. Old, not so old, and modern methods of diagnosis and treatment are discussed and the author's experience with them is candidly evaluated. Most of the important small details of technique and dosage, usually glossed over, are presented in clear detail supplemented by illustrations.

Although the procedures described are essentially those in current use at the Peter Bent Brigham Hospital in Boston, their application to general practice is assured by Dr. Levine's experience as a former general practitioner in rural New Hampshire.

John A. Boone, M. D.

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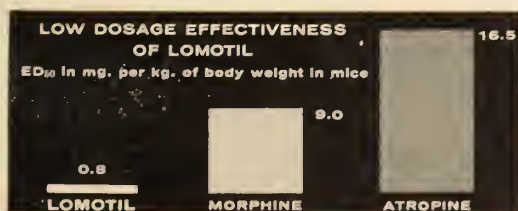
Whenever a paregoric-like action is indicated, Lomotil now offers positive antidiarrheal control ... with safety and greater convenience. In addition,

as a nonrefillable prescription product, Lomotil offers the physician full control of his patients' medication.

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Research in the Service of Medicine

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